ARIZONA GENERAL HOSPITAL

Authorization for Release of Medical Information

M.R. No. _____

PATIENT'S NAME _____ BIRTHDATE _____

ADDRESS _____ ZIP _____ PHONE # _____

DATES OF HOSPITAL SERVICE _____

PURPOSE OF DISCLOSURE _____

- ☐ All Pertinent Reports
- ☐ Consultation
- ☐ Discharge Summary
- ☐ EKG Reports
- ☐ History and Physical
- ☐ Billing Records
- ☐ Lab Reports
- ☐ Operative Report
- ☐ Pathology Report
- ☐ X-Ray Reports
- ☐ Other: Specify _____

I ACKNOWLEDGE, AND HEREBY CONSENT TO SUCH, THAT THE RELEASED INFORMATION MAY CONTAIN **CONFIDENTIAL HIV/AIDS RELATED INFORMATION, CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION, INFORMATION** RELATED TO **MENTAL HEALTH** AND/OR **ALCOHOL/DRUG USE**. _____(INITIAL)

I HEREBY AUTHORIZE: _____ TO RELEASE ALL OF THE ABOVE
COMPANY, PERSON, FACILITY

REQUESTED INFORMATION RELATIVE TO MY TREATMENT AND CARE TO:

_____
COMPANY, PERSON, FACILITY

_____ _____
ADDRESS PHONE

I understand that the hospital will not condition treatment on my signing this authorization. The hospital will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization. I also understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. To revoke my authorization, I must submit a written request to Arizona General Hospital Health Information Management Department. This authorization shall be considered invalid after six months from the date on which it is signed. I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulation and may be redisclosed by the person or organization that receives the information. There may be a charge subject to reasonable charging rates .

_____ _____
SIGNATURE OF PATIENT* DATE

_____
SIGNATURE OF OTHER AUTHORIZED PERSON

_____
RELATIONSHIP TO PATIENT

* If patient is a minor and information is to be released regarding the treatment for alcohol or drug abuse, both the patient and parent or legal guardian must sign.

Dignity Health.
Arizona General Hospital

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
714-L059 (REV 10/14)

PATIENT IDENTIFICATION LABEL