Phone number: 602-246-5605 Fax: 602-246-5835

Select method of delivery:

MAIL:_____ PICK-UP:_____ FAXED:_____ EMAIL:_____

Patient Name:_____ Date of Birth:_____

Account #:_____ Telephone Number:_____

Date(s) of Hospital Service:_____ Current Address:_____

Email Address:_____

PLEASE RELEASE THE FOLLOWING INFORMATION:

☐ HISTORY & PHYSICAL ☐ CONSULTS ☐ LAB/EKG/RADIOLOGY ☐ DISCHARGE SUMMARY
☐ OPERATIVE REPORTS ☐ EMERGENCY DEPARTMENT ☐ ALL ☐ OTHER:_____

THE PURPOSE OF THIS REQUEST IS FOR:

☐ The Disclosure is at my (patient's) request ☐ Government Agency / Police ☐ Personal Use
☐ Further Medical Care ☐ Attorney / Legal Investigation ☐ Insurance
☐ Disability Determination ☐ View Medical Records On Site

I understand that Abrazo Community Health Network may charge me a per page fee for the copying services necessary to complete my request.

I HEREBY AUTHORIZE:

☐ Abrazo Arizona Heart Hospital, Phoenix AZ ☐ Abrazo Mesa Campus, Mesa AZ ☐ Abrazo Surprise Campus, Surprise AZ
☐ Abrazo Maryvale Campus, Phoenix AZ ☐ Abrazo West Campus, Goodyear AZ ☐ Abrazo Arrowhead Campus, Glendale AZ
☐ Abrazo Scottsdale Campus, Phoenix AZ ☐ Abrazo Central Campus, Phoenix AZ ☐ Abrazo Buckeye Emergency Center, Buckeye AZ
☐ Abrazo Peoria Emergency Center, Peoria AZ

☐ Other Healthcare Entity:_____

TO DISCLOSE PROTECTED HEALTH INFORMATION RELATIVE TO MY TREATMENT AND CARE TO:

_____
COMPANY, PERSON, FACILITY

ADDRESS:_____
STREET CITY STATE ZIP CODE

I understand that I may revoke this authorization at any time with a written request, except to the extent that action based on this authorization has already been taken. I can read the Hospital's Notice of Privacy Practices for more details. This consent will expire automatically 365 days (1 year) from date on which it is signed. Any further disclosure of medical record information by the recipient(s) may no longer be protected by the federal privacy regulations and may be re-disclosed by the recipient(s). I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein. A photocopy of this form is valid. I understand that the information released in accordance with this medical authorization may include information concerning communicable disease such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency (AIDS), mental illness, chemical or alcohol dependency.

By accepting the custody of the digital disk/film copies, the patient or designated recipient accepts the risk associated with its loss or theft, in recognition that the data is readable via standard computer programs and as a result, patient privacy is not guaranteed.

_____ _____
Patient Signature Date

If patient is unable to consent by reason of age or some other factor, state reasons:_____

_____

_____ _____ _____
Legally Authorized Representative Date Relationship to Patient

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

I affirm that the patient is deceased, that no personal representative of his estate has been appointed, and that I am the patient's

_____ _____ _____
Relationship Signature Date

Identity of Requestor Verified via: ☐ Photo ID ☐ Matching Signature ☐ Other specify:_____

Verified by:_____ Date:_____