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:_____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about mental health or mental retardation services
☐ Psychotherapy Notes created by a mental health professional
☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ Information about sexually transmitted diseases
☐ Information about alcohol or drug abuse treatment program services
☐ Information about sexual assault
☐ Information about child abuse and neglect

I HEREBY AUTHORIZE:

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

☐ RECIPIENT: **Name of person or class of persons to whom Abrazo Community Health Network may disclose my health information:**_____

☐ **Address of the recipient or where my health information should be delivered:**

_____
STREET CITY STATE ZIP CODE

TERM: **This Authorization will remain in effect (if left blank below, this authorization will remain in effect for 365 days or one year):**

☐ **From the date of this Authorization until the _____ day of _____, 20_____.**
☐ **Until Abrazo Community Health Network fulfills this request.**
☐ **Until the following event occurs:**_____
☐ **Other:**_____

PURPOSE: **I authorize Abrazo Community Health Network to use or disclose my health information (including the highly confidential information (selected above, if any) during the term of this Authorization for the following specific purpose(s):** [Note: “at the request of the Patient” is sufficient if the Patient is initiating this Authorization]:

☐ 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 understand that once Abrazo Community Health Network discloses my health information to the recipient, Abrazo Community Health Network cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and State law governing the use and disclosure of my health information.

I understand that Abrazo Community Health Network may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Abrazo Community Health Network; except, however, if my treatment at Abrazo Community Health Network is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Abrazo Community Health Network may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Abrazo Community Health Network's Privacy Office at the address listed below. The revocation will be effective immediately upon Abrazo Community Health Network's receipt of my written notice, except that the revocation will not have any effect on any action taken by Abrazo Community Health Network in reliance on this Authorization before it received my written notice of revocation.

I may contact Abrazo Community Health Network's Medical Records Office by mail at:
10020 N 25th Ave; Phoenix AZ, 85021
by telephone at: 602-246-5605 or by e-mail at: ROI@abrazohealth.com

---

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly, and voluntarily authorize Abrazo Community Health Network to use or disclose my health information in the manner described above.

_____ _____
Signature of Patient **Date**

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____
Signature of Authorized Personal Representative Date Relationship to Patient

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

Verified by:_____ Date:_____