AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information: *(Please print)*

Patient Name: ____

Date of Birth: ______________________ Social Security Number: _____-_____-______

Address: ____

I authorize Gilbert Hospital to release information to:

____
Name of designated recipient

____
Address City, State, Zip Code

____
Phone Number Fax Number

☐ **Records to be Picked-Up**
☐ **Records to be Mailed**
☐ **Records to be Faxed to Care Provider**

Information to be Released:

☐ The most recent 6 months of pertinent information
(ER doctor report, dictated chart notes, labs, x-rays and special tests)
☐ All medical records
☐ Specific information (Please specify): ____

____

Purpose for which Disclosure is being made:

☐ For the Patient/Patient Representative's Personal Use or Records
☐ Continued Patient Care
☐ Worker's Compensation
☐ Insurance Coverage or Payment for Care
☐ Attorney's Office
☐ Other (Please specify): ____

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for the records to be released.

* **EXCLUDE the following information from the records released:** *(please initial)*

_____ Drug/Alcohol abuse/treatment & diagnosis

_____ Sexually Transmitted Diseases

_____ HIV/AIDS diagnosis/treatment/testing

_____ Mental Illnesses or Psychiatric diagnosis/treatment

(continued from reverse side)

Notice:

Gilbert Hospital and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state and federal confidentiality laws.

* Disclosure per title 42 CFR Part 2, Federal Register/Vol. 52, No. 110/6-9-87

My Rights:

- I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. One exception is if you come to Gilbert Hospital for an employer physical or other treatment where the purpose is to create health care information for a third party. In that situation we can not treat you if you do not sign this authorization.
- I may revoke this authorization at any time, with some exceptions, provided that I do so in writing and submit the request to Medical Records. The revocation will take effect when Gilbert Hospital receives it, except to the extent that Gilbert Hospital or others have already relied on it.
- I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
- I am entitled to receive a copy of this Authorization.

Expiration of Authorization:

Unless otherwise revoked, this Authorization expires________________________________.
If no date is indicated, this Authorization will expire 90 days after the date of signing.

I understand the matters discussed on this form. I release Gilbert Hospital, its employees, agents, officers, directors and medical staff members from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signature:

____

Signature of Patient or Patient's Representative   Date

____

Printed Name of Patient or Patient's Representative

____

If signed by Someone Other Than the Patient,
State your Relationship to the Patient and Your Authority to Act for Patient (Please attach evidence, if appropriate)