Phoenix Baptist Hospital
An Affiliate of Abrazo Health Care

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Mail_____
Pick UP_____
Faxed_____
Review on site___

Patient Name_____ Telephone No_____
Date(s) of Hospital Service_____ MR#_____ Date of Birth_____
Address_____

PLEASE RELEASE THE FOLLOWING INFORMATION:

☐ HISTORY & PHYSICAL ☐ CONSULTS ☐ LAB/X-RAY/EKG
☐ DISCHARGE SUMMARY ☐ OPERATIVE REPORTS ☐ OTHER:_____

In addition to the general authorization to release records, I authorize the provider to use or disclose information related to:

_____AIDS/HIV _____Psychiatric Illness _____Alcohol and/or Drug Abuse

THE PURPOSE OF THIS REQUEST IS FOR:

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

Phoenix Baptist Hospital
Health Information Department
2000 w. Bethany Home Rd
Phoenix, AZ 85015

I HEREBY AUTHORIZE:_____
COMPANY, PERSON, FACILITY
_____ TO DISCLOSE PROTECTED
ADDRESS
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 three months 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 redisclosed 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.

_____ _____
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.

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_____