



**St. Joseph's Hospital and Medical Center**  
**CHW**  
 350 West Thomas Rd.  
 Phoenix, AZ 85013

**AUTHORIZATION FOR USE OR DISCLOSURE OF  
 PROTECTED HEALTH INFORMATION**

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all  
 information requested may invalidate this authorization.

**USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:**

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Other Names Used: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Medical Record or Account#: \_\_\_\_\_  
 (Hospital use only)

I AUTHORIZE : \_\_\_\_\_  
 (Facility or other provider)

TO DISCLOSE TO: \_\_\_\_\_  
 (Persons/organizations authorized to receive the information)

at the following address: \_\_\_\_\_  
 (street, city, state and zip code)

**THE FOLLOWING RECORDS**, specific types of health information, or records for the date(s) of treatment as  
 specified [check applicable box(es)]:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Pertinent Information<br>(H&P, Discharge summary, Consultation,<br>Operative report, Path report, Lab,<br>x-ray, & emergency department report) | <input type="checkbox"/> Electrocardiograms (EKGs)<br>(EKGs) | <input type="checkbox"/> Billing Records   |
| <input type="checkbox"/> Consultation Reports  | <input type="checkbox"/> Emergency Room                      | <input type="checkbox"/> Procedure Reports |
| <input type="checkbox"/> Discharge Summary   | <input type="checkbox"/> History and Physical                | <input type="checkbox"/> Progress Notes    |
| <input type="checkbox"/> Date(s): _____  | <input type="checkbox"/> Laboratory Tests                    | <input type="checkbox"/> X-ray Reports     |
|  | <input type="checkbox"/> Medications                         | <input type="checkbox"/> Pathology Report  |

Other(s): \_\_\_\_\_

**ALL RECORDS** regarding my treatment, hospitalization, and outpatient care.

A separate authorization is required for the use or disclosure of psychotherapy notes or research health information.

**SENSITIVE INFORMATION:** The information disclosed may include the following (initial applicable lines below):

- \_\_\_\_\_ Genetic testing information  
 \_\_\_\_\_ HIV related information and other communicable diseases  
 \_\_\_\_\_ Physical and/or sexual abuse

