WHITE MOUNTAIN REGIONAL MEDICAL CENTER

**118 S. Mountain Ave.**

**Springerville, Az 85938**

**Patient Authorization for Disclosure of Health Information**

Patient Name: _____ Date of Birth: _____/_____/_____
Address: _____ City: _____
State: _____ Zip: _____E-mail Address: _____
Phone: _____

I request that my protected health information (PHI) from White Mountain Regional Medical Center (WMRMC) be disclosed to:

Recipient Name:

_____
Address: _____City: _____

State: _____ Zip: _____ E-mail Address: _____
Phone: _____Fax (healthcare provider only): _____

I authorize the following PHI to be released from my medical record(s):

☐Emergency Room Record ☐Laboratory Report(s) ☐Radiology Report(s) ☐Immunization Record Abstract/ Summary (Includes Discharge Summary, History & Physical, Operative Report(s), Consultations, and Test Results)

☐Itemized Billing Records

Other (specify):_____

Covering the period of healthcare from: Specific Date(s): _____ through _____ OR all encounters/visits _____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse. State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records ☐Yes ☐No Dates: _____
HIV Testing and Results ☐Yes ☐No Dates: _____

Mental Health ☐Yes ☐No Dates: _____
Psychotherapy Records ☐Yes ☐No Dates: _____

Purpose for requesting information:

☐Legal ☐Insurance ☐Personal ☐Continuation of Care ☐Other (please specify):

_____

Disclosure Format (Paper is default if not marked.): ☐US Mail – paper format ☐Fax (healthcare provider only) ☐CD/flash drive ☐Other (please specify):

_____

By signing this authorization form, I understand that:

• Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
• I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Medical Records Department at the following address:
118 South Mountain Ave., Springerville, AZ 85938
. Revocation will not apply to information that has already been disclosed in response to this authorization.
• Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire 6 months from the date signed.
• Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
• Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal privacy rules.

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Print Name Relationship to Patient (if applicable)

(For Office Use Only)

Medical Record Number: _____ Date records released: _____

Sent: ☐ Picked up: ☐

Identification verified by (copy of ID must be included): _____

Name of authorized Medical Records Personnel