Wickenburg Community Hospital and Clinics
520 Rose Lane
Wickenburg, AZ 85390
HIM Phone: 928.684.4364
HIM Fax: 928.684.9406

AUTHORIZATION FOR USE or DISCLOSURE OF HEALTH INFORMATION

Patient Information:
Patient Full Name: ______________________ Date of Birth: _____/_____/______
Patient Address: ______________________ Home Phone: ______________________
City: ______________ State: ________ Zip: ________ Work Phone: ______________________

Email Address:

Release of Information **To/From**:
Name/Facility: ______________________ Attention: ______________________
Address: ______________________ Phone: ______________________
City: ______________ State: ________ Zip: ________ Fax: ______________________
Email Address for record delivery: ______________________ ☐ ______________________

Purpose of Request: ☐ Personal ☐ Legal Other: ______________________
☐ Continuity of Care: For Dr: ______________________

Specific Information to be Released:
Date(s) of Services: ______________________
☐ Pertinent Information (includes H&P, Discharge Summary and other dictated reports, EKG, labs and radiology)
☐ Clinic Records ☐ Other: ______________________

Authorization to Release Protected Information: *Required – Complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the requested medical records.

Check one	*Initial each line*
___I DO/ ___ **I DO NOT** want **Behavioral Health/Psychiatric Treatment Notes** released	____
___I DO/ ___ **I DO NOT** want information about **Mental Health** release	____
___I DO/ ___ **I DO NOT** want **AIDS/HIV & Other Communicable Diseases** test results released	____
___I DO/ ___ **I DO NOT** want information about **Alcohol and/or Substance Abuse** release	____
___I DO/ ___ **I DO NOT** want information about **Genetic Testing** released	____

Expiration: This authorization will expire after **one year**.

____
Patient's Signature **Date**

____
***Parent/Legal Health Care Representative Signature** **Date**

***A copy of any Medical Power of Attorney / Health Proxy must be provided, if requestor is the MPOA / Health Proxy.**

140-2017-002