Wickenburg Community Hospital

Community Hospital, Wickenburg, 520 Rose Lane
Wickenburg, AZ 85390
HIM Phone: 928-684-4364 HIM Fax: 928-684-9406

Authorization to Disclose Health Information Instructions

1. **Name, DOB, Address, Phone, and Email:** Please fill out this information completely.

2. **I Hereby Authorize:** This is the facility that has your medical records, and you want them to release them.

3. **To Release To:** This is the facility that you want your medical records to go to. Please make sure you have at minimum phone and fax number.

4. **Date(s) of Service:** Please be specific with date or write "Any" then we can then reuse this authorization up to a year from the date it is signed.

5. **Purpose:** Please check or fill in what the reason is for these records.

6. **Delivery Method:** Please check how you want to get your records. (*If you choose to have it emailed you will need to check "Do" or "Do Not" want record encrypted.*)

7. **Excluded Records:** Please check if you want any of these records from the list "Excluded" from this release.

8. **Signature:** Please have patient or patient's representative sign. (If not patient, need to fill in relationship to patient and reason patient is unable to sign.)

9. **Date:** Please date with today's date.

We are required to have all of this completed for HIPAA regulations. Note this authorization is good for one year from the date it is signed.