Date: ____________________

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Information: (Please Print)

Patient Name: ________________________________ Date of Birth: __________________

Social Security Number (*optional*): _____-_____-_____ Phone Number: __________________

Address: ____

I authorize **Santa Cruz Valley Regional Hospital** to ☐ release ☐ receive information to/from:

Name:	
Address:	City, State, Zip Code:
Phone Number: 1( )	Fax Number: 1( )

☐ Records to be picked-up by: ____

☐ Records to be faxed to health care provider identified above

☐ Records to be mailed

Information to be released:
Please provide information in my medical records for date(s) of service from ___________ to ______________
☐All medical records ☐ History & Physical ☐ Laboratory Tests ☐ Consultation Reports
☐X-Rays/Imaging: ☐Reports ☐ Images

Purpose of the Release is:
☐Personal Use ☐Continued Patient Care ☐ Worker's Comp ☐ Insurance Coverage or Payment for care.
☐Attorney's Office ☐Other: ______________________________

Patient Authorization: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, genetic testing, or psychiatric treatment. I give my specific authorization for the records to be released.

EXCLUDE the following information from the records release: (Please Initial)

_____Drug/Alcohol abuse treatment and/or diagnosis

_____HIV/AIDS testing, treatment and/or diagnosis

_____Sexually Transmitted Diseases treatment and/or diagnosis

_____Mental Illness or Psychiatric treatment and/or diagnosis

Notice: Santa Cruz Valley Regional Hospital and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state and federal confidentiality laws.

My Rights: I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time, with some exceptions provided that I do so in writing and submit the request to Medical Records. The revocation will take effect when Santa Cruz Valley Regional Hospital receives it, except to the extent that Santa Cruz Valley Regional Hospital or others have already relied on it. For more detailed information on when I can and cannot revoke this Authorization, I can read the Santa Cruz Valley Regional Hospital Notice of Privacy Practices. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under the Privacy Laws. I am entitled to receive a copy of this authorization.

Expiration of Authorization: Unless otherwise revoked, this Authorization will expire on the following date, event or condition: ______________________________. **Information authorized on this release is valid for six (6) months (unless otherwise specified) after the date this authorization is signed.**

I understand the matters discussed on this form. I release Santa Cruz Valley Hospital, its employees, agents, officers, directors and medical staff members from any legal responsibility for the disclosure of the above information to the extent indicated and authorized herein.

There may be reasonable charge for copies of your medical records.

____ ____________________
Signature of Patient or Legally Authorized Representative Date

____
Printed Name of Patient or Legally Authorized Representative

____
If signed by a Legally Authorized Representative; State your relationship to the patient and your authority to act for patient (please attach evidence, if appropriate)

If requesting records from Santa Cruz Valley Regional Hospital please mail, fax or deliver this form in person to:

Santa Cruz Valley Regional Hospital
Attention: Health Information Department
44455 S. I-19 Frontage Rd.
Green Valley, AZ 85614
Fax: 1(520)393-4941

For SCVRH use only:
Disclosure Completed by Employee: ______________________________ Date: ____________
☐ Requestor ID Verified Initials: ______________ ☐ Request entered into EMR

MR-044 (Revised 07/18/2019)