Mountain Heart™
A Northern Arizona Healthcare partner

Please allow 3 business days for Records

# Medical Records Release Authorization

2000 S. Thompson St., Flagstaff, AZ 86001 Main (928) 226-6400 Fax (928) 226-6410

Patient Name_____ Maiden Name_____ SS#_____

Date of Birth_____ Home Phone_____ Cell/Work_____

Address_____ City/State/Zip_____

Email Address:_____

## A) I hereby authorize records FROM:

Name Mountain Heart

Address 2000 S. Thompson St.

City/State/Zip Flagstaff, AZ 86001

Phone #928-226-6400 Fax# 928-226-6410

## B) To be released TO:

Name _____

Address _____

City/State/Zip _____

Phone #_____ Fax# _____

## C) For the purpose of:

___Litigation ___Disabiltiy

___Insurance ___Work Comp

___Self/Personal Copy ___Other

___Transfer or Continuity of Care

Date Range_____ to_____

- O Physician Office Notes
- O Cardiology/EKG Reports
- O Immunizations
- O Lab/Path Reports
- O Operative/Procedure Reports
- O Radiology/XRay/MRI Reports
- O Other_____ O Minimum Necessary

**CIRCLE ONE: PICK UP OR MAIL RECORDS**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order assure treatment. I understand that any disclosure of information carries with it the potential for an authorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

**I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

_____ _____ ****Subject to Fees**

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date:_____

(Expiration date of authorization)