Dignity Health. Yavapai Regional Medical Center

Dignity Health. Yavapai Regional Medical Group

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME (PLEASE PRINT)	DATE OF BIRTH
NAME OF PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE INFORMATION	PHONE #:
ADDRESS	

CITY	STATE	ZIP

PURPOSE FOR DISCLOSURE

DATE(S) OF SERVICE

RELEASE INFORMATION FROM

- ☐ All YRMC facilities
- ☐ YRMC West
- ☐ YRMC East
- ☐ YRMC DEW (Vein Center, Wound Care)
- ☐ PMI
- ☐ PVMI
- ☐ WC OP Building
- ☐ EC OP Building
- ☐ All YRMG Clinics (Formerly Physician Care)
- ☐ List specific YRMG Clinic: ____________

INFORMATION TO BE RELEASED

- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Consultation Report
- ☐ Operative/Endoscopy Report
- ☐ Cath/Angio Report
- ☐ ER Record
- ☐ YRMG Clinic Notes
- ☐ Laboratory Report
- ☐ Pathology Report
- ☐ EKG/ECHO Report
- ☐ Respiratory Report
- ☐ Rehabilitation Report
- ☐ Immunization Records
- ☐ Other: _____________
- ☐ Radiology Report
- ☐ Medical Records on CD
- ☐ Images on CD
- ☐ Billing Records

SENSTITIVE INFORMATION TO BE DISCLOSED

- ☐ AIDS/HIV and other communicable disease
- ☐ Behavioral health care /mental health/psychiatric care
- ☐ Alcohol and/or drug abuse treatment
- ☐ Genetic testing information
- ☐ Treatment consented by a minor (12 years or older) that is protected by State and Federal Law (AIDS/HIV, contraception, prenatal care, abortion, sexually transmitted diseases, sexual assault, alcohol and/or drug abuse)

I hereby authorize Dignity Health Yavapai Regional Medical Center (DH YRMC) and YRMC Physician Care to furnish to the Authorized Person or Organization named above a copy of the information related to type of care or service(s) indicated above that was provided to the Patient for the date(s) stated above.

This authorization will be considered invalid after one year OR based on expiration date or event as noted here.

EXPIRATION DATE OR EVENT

I may revoke this authorization at any time, with some exceptions, except to the extent DH YRMC has already taken action based on this authorization. A revocation of this authorization will not apply to information that has already been released in response to this Authorization. I may revoke this authorization by providing written notice of revocation to DH YRMC's Health Information Management Department.

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I understand that: (1) authorizing the disclosure of this health information is voluntary; (2) treatment, payment, or enrollment or eligibility for benefits is not conditional based on this authorization; and (3) if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

I understand the matters discussed on this form, and I received a copy. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE	DATE
NAME OF PERSON SIGNING (PRINTED)	
DESCRIPTION OF REPRESENTATIVE'S AUTHORITY TO ACT FOR PATIENT	
RELATIONSHIP TO PATIENT	