



**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

COMPLETE ALL SECTIONS, DATE AND SIGN

I, \_\_\_\_\_, hereby voluntarily authorize the disclosure of information from my record.

*(Name of Patient)*

II. The information is to be disclosed by:

And is to be provided to:

NAME OF FACILITY: Wassaja Memorial Health Center, Medical Records Department		NAME OF PERSON/ORGANIZATION/FACILITY:	
ADDRESS: PO Box 17779		ADDRESS:	
CITY/STATE: Fountain Hills, AZ 85269-7779	PHONE #: 480-789-7890 FAX #: 480-837-1270	CITY/STATE:	PHONE #: FAX #:

III. The purpose or need for this disclosure is:

- Further Medical Care   
  Attorney   
  School   
  Research  
 Personal Use   
  Insurance   
  Disability   
  Other (Specify) \_\_\_\_\_

IV. The information to be disclosed from my health record: (check appropriate box(es) below:

- Entire Record  
 Only information related to (specify): \_\_\_\_\_  
 Only the period of events from \_\_\_\_\_ to \_\_\_\_\_  
 Other (specify) \_\_\_\_\_  
 Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- Alcohol/Drug Abuse Treatment/Referral   
  HIV/AIDS-related Treatment  
 Sexually Transmitted Diseases   
  Mental Health (Other than Psychotherapy Notes)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Records department, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event.

*(Enter if different from one year after date below)*

I understand that WASSAJA MEMORIAL HEALTH CENTER will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the privacy Act of 1974 [5 USC 552a]

SIGNATURE OF PATIENT:	DATE:
SIGNATURE OF AUTHORIZED REPRESENTATIVE (State relationship to patient) or Witness (if signature is thumbprint or mark)	DATE:

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 522a(i)(3)).

PATIENT IDENTIFICATION:	NAME (Last, First, MI):	RECORD NUMBER:
	ADDRESS: _____	
	CITY _____, STATE _____	
	DATE OF BIRTH: _____	