HONORHEALTH™

HonorHealth.com

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

❑**Scottsdale Osborn Medical Center**
Health Information Management
7300 E. Fourth St., Suite 100
Scottsdale, AZ 85251-6403
(480) 882-4040
FAX: (480) 882-5841

❑**Scottsdale Shea Medical Center**
Health Information Management
9003 E. Shea
Scottsdale, AZ 85260
(480) 323-3213
FAX: (480) 882-5841

❑**John C. Lincoln Medical Center**
Health Information Management
250 E. Dunlap Ave.
Phoenix AZ 85020
(602) 870-6352
FAX: (602) 678-3217

❑ **Deer Valley Medical Center**
Health Information Management
19829 N. 27th Ave.
Phoenix, AZ 85027
(623) 879-5571
FAX: (623) 879-5559

❑ **For Scottsdale Thompson Peak Medical Center Requests please mail your requests to the Shea Campus**

❑ **For Sonoran Health and Emergency Center requests, please mail your requests to the Deer Valley Campus**

PATIENT IDENTIFYING INFORMATION:

Patient Full Name: _____ Date of Birth: _____
Patient Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Work Phone: _____

Release Information To:

I hereby authorize HonorHealth to release my medical record information to: ❑ Mail Copies To: ❑ Hold for Patient Pick-up
Name/Facility: _____ Attention: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Fax: _____
Purpose of Request: ❑ Personal ❑ Continuing Care ❑ Legal ❑ Other: _____

Specific Information to be Released:

Date(s) of Service: _____
❑ Pertinent Information* (includes H & P, discharge and other dictated reports, EKG, labs and radiology)
❑ Discharge Summary ❑ History & Physical ❑ Operative Report ❑ ER Report ❑ Consultation Report
❑ EKG ❑ Diagnostic Imaging Reports ❑ EEG ❑ Lab Results ❑ Pathology Reports ❑ Diagnostic Films (specify): _____ ❑ Complete Records: Date of Visit _____ ❑ Other (specify): _____ ❑ Family Practice Clinic (please request directly from the clinic)
❑ CD ❑ Paper Records

I authorize the provider to use or disclose information related to: ❑AIDS/HIV and other Communicable Diseases
❑ Genetic Testing Information ❑ Psychiatric Care Reports ❑ Alcohol and/or Drug Abuse Treatment

I understand that HonorHealth will not condition treatment on my signing this authorization. HonorHealth will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I also understand that I may revoke this authorization at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read HonorHealth's Notice of Privacy Practices.

To revoke my authorization, I must submit a written request to HonorHealth. Unless I *revoke* the authorization earlier, it will expire upon its completion or *60 days* from date of signature, whichever comes first. I understand that, 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. I release the provider, its employees, officers and directors, medical staff members, and business associates information to the extent indicated and authorized herein.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative Relationship to Patient or Description or Authority to Act for Patient

Barcode: DTHIMAUTH

For Official Use Only: (Rev 02/05/2015)
Acct#:_____Delivery Method: _____
Initials: _____Date:_____ Time: _____