

Network Support Services (NSSC)**Attn: Health Information Management Release of Information****2500 W. Utopia, Phoenix, AZ 85027****Phone: (480) 882-4040****FAX: (480) 882-5841** For NOAH Clinics please mail to appropriate location For HonorHealth Medical Groups send to the above address**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: Patient Pick-up (Specify Facility Name) Osborn Shea Thompson Peak
 Deer Valley John C. Lincoln Sonoran

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 Itemized statement Account review CD Paper Records MyChart Email _____**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 Notice of Privacy Practices.

To revoke my authorization, I must submit a written request to the 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: _____