HONORHEALTH™

HonorHealth.com

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

❑**Scottsdale Osborn Medical Center**	❑**Scottsdale Shea Medical Center**	❑**John C. Lincoln Medical Center**	❑ **Deer Valley Medical Center**
Health Information Management	Health Information Management	Health Information Management	Health Information Management
7301 E. Fourth St., Suite 10	9003 N. Shea	250 E. Dunlap Ave.	19829 N. 27th Ave.
Scottsdale, AZ 85251-6403	Scottsdale, AZ 85260	Phoenix AZ 85020	Phoenix, AZ 85027
(480) 882-4040	(480) 323-3213	(602) 870-6352	(623) 879-5571
FAX: (480) 882-5841	FAX: (480) 882-5841	FAX: (602) 678-3217	FAX: (623) 879-5559

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

❑ **For Sonoran Health and Emergency Center requests, please mail or fax 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 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: _____