HONORHEALTH **Authorization to Use or Disclose Protected Health Information**

HonorHealth Facility:

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❑ **For Thompson Peak Hospital 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: _____
E-Mail Address: _____

Release Information To: ❑ Hold for Patient Pick-up ❑ Mail Copies To:
I hereby authorize HonorHealth to release my medical record information to:

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 (Request should mailed directly to the clinic)

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

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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: _____