

Authorization for Use and Disclosure of Protected Health Information

Print Patient Last Name _____ First _____ Middle _____
 Address _____ City _____ State _____ Zip _____
 Social Security Number _____ Date of Birth _____ Phone _____

I authorize Mountain Vista Medical Center to disclose protected health information to:

Name _____ Phone/Fax Number _____
 Address _____ City _____ State _____ Zip _____
 Call this phone number when records are available for pick up at hospital _____

PURPOSE FOR USE/DISCLOSURE

Approximate date(s) of service to be used/disclosed _____

INFORMATION TO BE USED / DISCLOSED

- | | |
|---|--|
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Pathology report |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Lab reports |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Radiology reports/films |
| <input type="checkbox"/> Operative/procedure report | <input type="checkbox"/> EKG report(s) |
| <input type="checkbox"/> Consultation report(s) | |
| <input type="checkbox"/> Other _____ | |

Specific Authorization to Disclose Sensitive Records

I UNDERSTAND THAT THIS AUTHORIZATION IS TO INCLUDE USE / DISCLOSURE OF: (please check and initial)

- | | | | |
|---|----------------|---|----------------|
| <input type="checkbox"/> Alcohol and/or drug abuse records | Initials _____ | <input type="checkbox"/> Psychiatric records | Initials _____ |
| <input type="checkbox"/> Sexually transmitted disease information | Initials _____ | <input type="checkbox"/> HIV/AIDS information | Initials _____ |

*This information is disclosed from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization is NOT sufficient for this purpose.

- I understand that I may revoke this authorization, in writing, at any time except to the extent that Mountain Vista Medical Center has already relied on this authorization.
 - I understand that I may revoke this authorization by sending or faxing a written notice to the Privacy Officer, at Mountain Vista Medical Center, 1301 South Crismon Road, Mesa, AZ 85209 or fax 480-358-6407, stating my intent to revoke this authorization.
 - Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires is one year after signing and dating this form, unless otherwise documented here: _____
 - I understand that Mountain Vista Medical Center may not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization form.
 - I understand that information being disclosed may be subject to re-disclosure by the recipient and may no longer be protected by the Federal privacy law, if the recipient is not a "covered entity".
- If box is checked, the hospital will receive direct or indirect financial compensation in connection with the use or disclosure of your information for marketing purposes.

Signature (Patient or Patient's Legal Representative) _____

Date _____

Printed Name of Legal Representative _____

Relationship to Patient _____

PLEASE NOTE: THIS FORM MUST BE COMPLETED IN ITS ENTIRETY. THANK YOU FOR YOUR COMPLIANCE.



Account Number:	MR Number:
Patient Name:	
Admit Date:	

 Mountain Vista MEDICAL CENTER	DOB	Age	Sex	HT	WT	RM-BD	PT	SVC	FC	
	Allergies:									
	Attending Physician Name:									

1301 S. Crismon Rd.
Mesa, AZ 85209