COTTONWOOD MEDICAL CENTER, Ltd.

Outgoing Medical Records

Authorization to use or disclose protected health information

PLEASE PRINT

I hereby authorize use or disclosure of the named individual's health information as described below:

PATIENT NAME:	DATE OF BIRTH: / /	SOCIAL SECURITY NUMBER:
ADDRESS (CITY, STATE, ZIP CODE):		TELEPHONE NUMBER:

THE FOLLOWING ORGANIZATION IS AUTHORIZED TO MAKE THE DISCLOSURE:

Cottonwood Medical Center, Ltd.
560 N. Camino Mercado Ste: 7
Casa Grande, AZ 85222

THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING ORGANIZATION:

NAME: ____

ADDRESS: ____

CITY, STATE, ZIP CODE: ____

TELEPHONE: ____

THE FOLLOWING INFORMATION IS TO BE DISCLOSED:
(PLEASE CHECK ONE BOX FOR EACH ITEM)

YES	NO	
? ?	?	physician notes
? ?	?	lab results
? ?	?	x-ray reports
? ?	?	Immunizations
? ?	?	complete record
? ?	?	other ______________________________

PURPOSE OF REQUEST:

? ? **Specialist**
? ? **Transfer to new primary care physician**
? ? **Moving from area**
? ? **Insurance company**
? ? **Part-time resident**

TREATMENT DATES:

Sensitive information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Other rights:

a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in research study, my enrollment in the research study may be denied.
b) I understand that I may inspect or obtain a copy of the information used or disclosed.

Charges: I understand and agree that this office may charge me $.10 per page for copies, in addition to $10.00 for reasonable personnel costs in making the records available, and the actual cost of duplicating diagnostic data, such as x-rays.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (If I do not specify an expiration date, event, or condition, this authorization will expire in six months.)

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE:
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT:	Completed By: Date: