

Authorization For Use or Disclosure of Medical Record Information

13395 N. Marana Main Street, Marana, AZ 85653

Phone: (520)682-4111 ext 6085

FAX: (520)682-3817

Patient Information

Patient Full Name: _____ Date of Birth: _____
 Patient Address: _____ Home Phone: _____
 City: _____ State _____ Zip: _____ Work Phone: _____

Release of Information

I hereby Authorize Marana Health Center, Inc. (MHC), to receive my Medical Record Information from:

Doctor/Provider/Specialist: _____
 Facility: _____ Attention: _____
 Address: _____ Phone: _____
 City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: * Personal * Continuing Care * Legal * Insurance * Other _____

Information to be Released

PLEASE BE SPECIFIC - include dates of treatment & provider name if applicable.

_____ Date(s) of Treatment _____
 _____ Date(s) of Treatment _____
 _____ Date(s) of Treatment _____

Authorization for Release of Statutorily Protected Information

DO NOT Leave This Section Blank-The requested medical record MAY or MAY NOT contain information that is statutorily protected. protected. You must check either "Yes" or "No" and initial each category for MHC to properly process your medical record request.

Release Records? Check one		
	Yes	No
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Treatment Notes	<input type="checkbox"/>	<input type="checkbox"/>
HIV Tests & Related Information	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol and/or Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>

Initial Here: _____
 Initial Here: _____
 Initial Here: _____
 Initial Here: _____



Please confirm that you have checked "Yes" or "No" and initialed all 4 protected information categories above even if they do not necessarily apply to the patient's records. Note - If information is not released and/or form is incomplete, MHC may be unable to fulfill this request.

Sensitive Information

Please check below any category of sensitive information that you **DO NOT** want released.

Abortion Sexually Transmitted Disease AIDS/ARC
 Genetic Domestic Sexual Assault Other(s) _____

Patient's Signature _____ **Date:** _____

(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian _____ **Date:** _____

(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the health center took before it received the revocation.
- I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.
- I understand that my treatment or continued treatment by MHC Healthcare and its affiliates is in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.
- I understand that I may inspect or copy the information that is used or disclosed.

FOR INTERNAL USE ONLY

EMR Only Paper Chart (scanning completed)

Location _____ Employee _____ Date _____