AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize: **Benson Hospital**
450 S. Ocotillo
Benson, AZ 85602

Telephone: 520-720-6520
Facsimile: 520-720-6521

If you have a disability that requires this authorization in an alternative format or require a special accommodation to complete this form, you may request assistance from staff at Benson Hospital or from the Privacy Officer @ (520)720-720-6522.

To Release Confidential Health Information To:

_____ (Recipient Name) _____ (Street Address) _____ (City, State, Zip)

Telephone Number_____ Fax No._____

The following information from the medical record of:

Patient Name: _____ (first, last) Date of Birth :_____(mm/dd/yyyy)

Social Security No: _____-_____-_____ Date(s) of Treatment: _____ (from/to)

Information to be released:

____Abstract/Basics	____Blood Type	____Complete Chart	____Consultation	____Discharge Summary
____EKG/ECHO	____ER Records	____Face sheet	____History & Physical	____Itemized Bill
____Laboratory Reports	____Operative Record	____Pathology Report	____Progress Notes	____Radiology films/CD
____Radiology Reports	____Other (specify): _____			

The information specified above is to be released for the following purpose:

____Attorney ____Billing or Claims ____Patient Request ____Social Security

____Treatment/Consultation ____Workers Comp ____Other (specify) _____

(If the client initiates the authorization and does not elect to provide a statement of purpose, then the statement, "at the request of the individual" is adequate.)

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

_____ YES-Okay to release _____ NO-Do not Release

Time Limit and Right to Revoke

I understand this authorization will be valid for six (6) months from the date signed to release any records created up to the date of signature unless revoked prior to that time or unless otherwise specified as follows. Any records created after the date of this authorization will require a new authorization. I desire this authorization to be in effect until _____ (expiration date/event). Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at the above address.

Authorization and Re-disclosure

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my healthcare may not be conditioned on whether I sign this authorization form. I understand I may inspect or receive copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal and state privacy regulations. I have a right to limit the information disclosed. I authorize Benson Hospital to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for reproduction of record copies and/or CD's. A copy or facsimile of this authorization is as valid as the original.

____When checked I understand that the record is incomplete and that additional information may continue to be added. I understand that may request a complete copy of the record once the chart has been completed.

Preferred Method of Reproduction: ___ e-mail ___ Paper - The hospital will try to accommodate preference where practicable.

If faxing or emailing this request please include a legible copy of a valid driver's license.

_____ _____
Signature of Patient or Legal Representative **Date**

_____
Authority to sign if not Patient (Documentation may be required)

_____ _____
Signature of Witness/Benson Hospital Employee **Date**
____Photo ID verified by Benson Hospital Employee