Little Colorado Medical Center
Compassionate Care for Northeast Arizona

I authorize Little Colorado Medical Center to disclose protected health information ("PHI") from the health records of:

Patient name: _____Date of Birth_____

Address: _____Phone number: _____

I authorize PHI from _____[date] to _____ [date] to be disclosed to

_____ at _____ [address];

_____ [phone number if known; _____fax number if known].

Specific description of the information to be disclosed:

_____Discharge Summary
_____Operative Reports
_____Lab Tests
_____History and Physical Exam
_____X-ray Reports
_____Other (specify)_____

Specific description of the purposes of the disclosure:

_____Continued Patient Care
_____Insurance Coverage/Payment for Care
_____The disclosure is at my (the patient's) request.
_____Workers' Compensation
_____Other (specify) _____

I authorize the provider to use or disclose information related to (check all that apply):

_____AIDS/HIV and other Communicable Diseases
_____Behavioral Health Care/Psychiatric Care/Mental Health Information
_____Alcohol and/or Drug Abuse Treatment (*in compliance with* 42.CFR §2.31-§2.36)
Treatment for:_____

The provider will not deny me treatment if I do not wish to sign this form. I understand that 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 the provider's Notice of Privacy Practices.

To revoke my authorization, I must submit a written request to the Medical Record Department. Unless I revoke this authorization earlier, it will expire one year after date of signing unless otherwise specified_____.

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 from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative Relationship to Patient or Description of Authority to Act for Patient

Patient Consent verified_____

Identification verified_____

Staff Use Only

Acct#_____

Face Sheet
T-sheet x2
EMS
D/C
H&P
Orders
X-ray
Other_____
Operative
Pathology
Med Record
N Notes
Progress
Lab/EKG
ENTIRE

HANDED/MAILED/FAXED

Date: _____

By: _____

Reviewed 08/2022