

Authorization for Use or Disclosure of Medical Record Information

MR#: _____ (for office use only)

Patient Information:

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Release Information To:

I hereby Authorize John C. Lincoln Health Network to release my medical record information to:

- Mail Copies To: Hold for Patient Pick-up

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Purpose of Request: Personal Continuing Care Legal Other: _____

Specific Information to be Released:

Date(s) of Service: _____

- Pertinent Information* (includes H & P, discharge and other dictated reports, EKG, labs and radiology)
- | | | |
|--|---|--|
| <input type="checkbox"/> Family Practice Records | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History & Physical |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> ED Report | <input type="checkbox"/> Consultation Report |
| <input type="checkbox"/> EKG | <input type="checkbox"/> Diagnostic Imaging Reports | <input type="checkbox"/> EEG |
| <input type="checkbox"/> Lab Results | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Diagnostic Films (specify): _____ |
| <input type="checkbox"/> Complete Records: Date of Visit _____ | | <input type="checkbox"/> Other (specify): _____ |
- CD Paper Records

*John C. Lincoln will provide up to 40 pages of your record at no charge (only for patient care requests). Any additional pages will be provided at \$.25 a page plus a processing fee of \$15 for paper records or \$10 for a CD. Postage and handling will be added for mail requests.

Authorization to Release Protected Information:

***Required** – Complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient’s medical records.

- | | |
|---|---|
| <i>Check one</i> | <i>Initial each line to confirm choices</i> |
| <input type="checkbox"/> I DO/ <input type="checkbox"/> I DO NOT want Behavioral Health/Psychiatric Treatment Notes released | _____ |
| <input type="checkbox"/> I DO/ <input type="checkbox"/> I DO NOT want information about Mental Health released | _____ |
| <input type="checkbox"/> I DO/ <input type="checkbox"/> I DO NOT want AIDS/HIV & Other Communicable Diseases test results released | _____ |
| <input type="checkbox"/> I DO/ <input type="checkbox"/> I DO NOT want information about Alcohol and/or Substance Abuse released | _____ |
| <input type="checkbox"/> I DO/ <input type="checkbox"/> I DO NOT want information about Genetic Testing released | _____ |



Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete, we may be unable to fulfill this request.

My Rights:

I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization.

I understand that I may revoke this authorization at any time, with some exceptions, that being to the extent the hospital has acted on this authorization prior to the date we received the letter to revoke authorization.

To revoke my authorization, I must submit a written request to the same John C. Lincoln facility.

I am entitled to receive a copy of this Authorization.

Notice to Recipient:

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information without express written consent of the person to whom it pertains. The information being released will no longer be protected from re-disclosure by recipient.

This authorization will expire within 60 days unless I note here a specific date, event or condition.



Patient's Signature

Date

Parent/Legal Health Care Representative Signature*

Date

Released by

ID Used

Date

***A copy of any Power of Attorney must be provided, if requestor is the POA.**

- 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 hospital took before it received the revocation.
- I understand that under the applicable law the information used of described pursuant to this authorization may be subject to redisclosure by the and No longer subject to the protections of the privacy standard.
- I understand that my treatment or continued treatment by John C. Lincoln and its affiliates is 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.

Instructions for Submitting Form:

Completed forms can be mailed, faxed or delivered in person to the facility where you received services (Monday – Friday, 8:30 a.m. – 5 p.m.). A photo ID* must be provided with form (or provide legible copies for mailed/faxed requests).

*Accepted photo IDs include government-issued photo IDs and John C. Lincoln employee IDs

North Mountain Hospital

Attn: Health Information Department
250 E. Dunlap Ave.
Phoenix, AZ 85020
Phone: 602-870-6352
Fax: 602-678-3217
Office hours: M – F, 8:30 a.m. – 5 p.m.

Deer Valley Hospital

Attn: Health Information Department
19829 N. 27th Ave.
Phoenix, AZ 85027
Phone: 623-879-5571
Fax: 623-879-5559
Office hours: M – F, 8:00 a.m. – 4:30 p.m.

Form # **MR – 70** **Title:** Authorization for Use or Disclosure of Medical Record Information

Sponsor: Paula Hampton

Paper Color, if not White:

- Blue
- Yellow
- Goldenrod
- Green
- Pink
- Salmon
- Terra Green
- Tan
- Cherry
- Other:

Paper Size, if not 8-1/2 x 11: _____

- 1/2 Sheet
- Legal – 8-1/2 x 14

Print options, if not Portrait, 1-Sided:

- 2-Sided
- 2-Part NCR
- 3-Part NCR
- 4-Part NCR
- Other: