NORTHERN COCHISE COMMUNITY HOSPITAL

901 W. Rex Allen Drive, Willcox AZ 85643

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize Northern Cochise Community Hospital to disclose Protected Health Information (PHI) from the medical record of:

Patient's Name _____

Patient's Date of Birth _____

Patient's Address _____

Patient's telephone # (optional) _____

Patient's email address (optional) _____

Records Released to _____

Record Format (please circle one): Printed / USB / Disk / Email / Fax

Date(s) of Service _____

PLEASE INDICATE REQUESTED DOCUMENTS

- ☐ **History and Physical Examination**
- ☐ **Discharge Summary**
- ☐ **Emergency Room Physician Report**
- ☐ **Nursing Notes**
- ☐ **Transfusion Record**
- ☐ **Operative Reports**
- ☐ **Physician's Progress Notes**
- ☐ **Radiology reports / images**
- ☐ **Laboratory Results**
- ☐ **EKG Report / Rhythm Strip**
- ☐ **Physician's Orders**
- ☐ **Rehabilitation Notes**
- ☐ **Human Remains Release Form**
- ☐ **Medication Reconciliation Form**
- ☐ **Itemized Bill**
- ☐ **Wound Pictures**
- ☐ **Case Management Notes**
- ☐ **Dietary Notes**
- ☐ **Prescriptions**
- ☐ **Discharge Instructions**
- ☐ **Patient Belongs List**
- ☐ **Advanced Directives/POA**
- ☐ **Directory Opt Out**
- ☐ **Trend List Report**
- ☐ **Consent for Treatment**
- ☐ **Healthcare Decisions Form**
- ☐ **Operative Consents**
- ☐ **Receipt of Privacy Practices**
- ☐ **Face Sheet**
- ☐ **Notice of Noncoverage**
- ☐ **Medicare Notice(s)**
- ☐ **Pre-hospitalization Notes**

I AUTHORIZE THE PROVIDER TO DISCLOSE PHI RELATED TO:

- ☐ AIDS / HIV and other communicable disease
- ☐ Behavioral healthcare / Psychiatric care / Mental health information
- ☐ Alcohol and/or drug abuse treatment

ELECTRONIC STORED DOCUMENTS (Inpatient only)

☐	Patient Cumulative Report	☐	Administrative Medication Report
☐	Detail Rounds Report	☐	Shift Activity Report
☐	Current Care Plan Report	☐	Patient Chart Component Report
☐	Patient Care Profile Report	☐	Patient Care Notes Report
☐	Entire Patient Chart Report	☐	Incomplete Assessment Report
☐	Outstanding Outcome Report	☐	Work list Report
☐	Patient Detail Rounds Report	☐	Medication Profile Report
☐	Clinical History Profile Report	☐	Order Work list

I understand that the hospital will not condition treatment on my signing this authorization. The hospital will not deny me treatment if I do not wish to sign this form. I also understand that I may revoke this authorization at any time, with some exceptions. For more detail on revoking this authorization I can read the Hospital's Notice of Privacy Practices. To revoke this authorization I must submit a written request to the hospital's Privacy Officer.

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

Description of Authority to Act for Patient:

_____

Notes:

_____