Casa Grande Regional Medical Center
1800 E. Florence Blvd., Casa Grande, AZ 85222-5399
520-381- 6391 FAX: 520-381-6599

Authorization for Release of Confidential Medical Information

______________________ / ______________ ______________ ______________
(Patient Name) (Previous Name) (DOB) (MR#)

❒ I hereby authorize Casa Grande Regional Medical Center to release my medical records (i.e., send my records to the person/institution named below) **OR**
❒ I hereby authorize Casa Grande Regional Medical Center to obtain my medical records **FROM** the person/institution named below:

Name ______________________ Telephone # ______________

Address ______________________ City ______________ State/Zip ________

The purpose for releasing/obtaining these records is: (check all that apply)
❒ Continued Medical Care ❒ Insurance Application ❒ Disability Claim
❒ Legal Purposes ❒ Other (please specify)______________________

I understand that the information that is released may include diagnoses, prognoses, and/or treatment for physical and emotional illness, including treatment of alcohol and/or drug abuse and HIV test results.

The specific and relevant information to be released or obtained:
❒ Discharge Summary ❒ History and Physical ❒ Consultation Report ❒ Psychiatric/Psychological Evaluation
❒ Lab Reports ❒ Radiology Reports ❒ Operative Report ❒ Psychiatric Treatment Plan
❒ Other (please specify)______________________

Treatment Date(s):______________________

This authorization is effective until: ___________________________ (DATE OR EVENT THAT RELATES TO THE PATIENT OR THE PURPOSE FOR THE USE OR DISCLOSURE MUST BE ENTERED AND SHOULD NOT EXCEED 90 DAYS FROM THE DATE OF SIGNATURE. IF NO DATE OR EVENT IS ENTERED THE AUTHORIZATION IS VALID FOR 90 DAYS FROM THE DATE OF SIGNATURE.)

I understand I may revoke this authorization at any time by providing written notice of revocation, except to the extent that information was released, as authorized, prior to the notice of revocation. I further understand that I may inspect and receive a copy of the disclosed information.
The information that is used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and would therefore no longer be protected by this rule.

I understand this authorization is voluntary and I may refuse to sign it. My refusal to sign will not affect my eligibility for benefits, enrollment, payment for or coverage of services, or ability to obtain treatment unless the purpose of this authorization is for the use/disclosure of health information for a research study and I refuse to sign this authorization. In that instance, Casa Grande Regional Medical Center reserves the right to deny treatment associated with such research. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Casa Grande Regional Medical Center reserves the right to deny that health care.

I have read all of the above information and understand the nature of this authorization as evidenced by my signature below.

CHECK ONE OF THE FOLLOWING:
❒ I am the patient.
❒ Other – State authority to act as patient's legal representative (proof required.) ______________________

Date ______________ Patient ______________________

Date ______________ Other Representative ______________________

Date ______________ Witness ______________________

If any person physically unable to provide a signature desires to consent to this release, print his/her name on the appropriate signature line above and record below the signature of two (2) responsible persons who witness that such person understands the nature of this release and freely gave his/her consent.

______________________ ______________________
Witness of person unable to sign Date Witness of person unable to sign Date

CASA GRANDE REGIONAL MEDICAL CENTER RESERVES THE RIGHT TO CHARGE FOR COPYING MEDICAL RECORDS.

White – Medical Records **Yellow - Patient**