Hacienda HEALTHCARE
In special lives, we make a difference

Patient Name: _____

Facility/Location: _____

Authorization to Release Patient/Healthcare Information

Patient's Name: _____ Today's Date: _____
Date of Birth: _____ Social Security #: _____

I request and authorize Hacienda Healthcare 1402 E. South Mountain Drive, Phoenix, AZ 85042 to release healthcare information of the patient named above to:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

For the purpose of: _____
(if requested by patient or guardian, "at request of the individual" is sufficient)

This request and authorization applies to the following types of records: (**Please indicate types that may be released** - i.e., clinical summaries, lab reports, nurse's notes, alcohol/drug abuse information, behavioral health records, communicable disease information, or all Hacienda HealthCare medical records).

_____

_____

_____

AFFIRMATION OF RELEASE

I give _____ or the named provider permission to release only the information I have designated on this form to the individual(s) or provider(s) I have named and only for the purposes I have written. I understand that this release is valid for 12 months from the date of signing and that I may refuse to sign this authorization or revoke it at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records. **Copies of the records may be obtained with reasonable notice and payment of copying cost – currently a $10.00 search fee and $.10 cents per page.** As a patient requesting my own record, I can expect to receive copies within one business day after the Medical Records Office receives this Authorization. I further understand that if the person or entity that receives the above specified information is not an entity covered by the federal privacy regulations or a business associate of these entities, the information described above may be re-disclosed and no longer protected by the regulations. **By signing my name below, I also understand that the only way to ensure my privacy is to return this document to Hacienda HealthCare for processing in person, via fax, or by USPS mail to the attention of the Administrator or Medical Records.** Email or other electronic transmissions may not be secure.

Patient Signature (if applicable): _____ Date: _____

Legal Guardian Signature: _____ Date: _____

Relationship to Patient: _____

Administrator or Director of Social Services Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES 12 MONTHS AFTER IT IS SIGNED.

10/27/2010, 2/3/2011, 6/19/2013, 5/15/2014, 12/14/2016