Authorization for Release of Protected Health Information

Fax: 602-346-0591

PATIENT IDENTIFYING INFORMATION:

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

_____ _____ _____

City State Zip

Release Information To:

I hereby authorize The CORE Institute Specialty Hospital to release my medical record information to:

☐ Mail Copies To:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

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

Purpose of Request: ☐ Personal ☐ Continuing Care ☐ Insurance ☐ Disability ☐ Legal ☐ Other

Specific Information to be Released:

Date(s) of Service: _____

☐ All Pertinent Records (includes those listed below) ☐ Entire Medical Records

☐ Consultation ☐ X-rays/Images

☐ History & Physical ☐ Physical Therapy Notes

☐ Operative Report ☐ Notes

☐ EKG ☐ Vitals

☐ Laboratory ☐ Other _____

I understand that the above health records may include information which requires specific permission for release. I authorize the provider to use or disclose information related to:

(check and initial all that apply).	**Yes**	**No**	**Initials**
AIDS/HIV and other Communicable Diseases	☐	☐	_____
Alcohol and/or Substance Abuse Treatment	☐	☐	_____
Communicable Diseases	☐	☐	_____
Genetic Information	☐	☐	_____
Mental Health	☐	☐	_____

Delivery of Records:

Paper Request ☐ Mail ☐ Fax ☐ Hold for Patient Pick-up

Electronic Requests ☐ Secure Email ☐ EFax ☐ CD

NOTE: There is some level of risk that a third party could access your Protected Health Information (PHI) without your consent when electronic media or email is unencrypted. We are not responsible for unauthorized access to unencrypted media or email or for any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address for record delivery: _____

(Complete ONLY if requesting records via email)

Unencrypted data sent by email can be intercepted by unauthorized parties

6501 North 19th Avenue
Phoenix, AZ 85015
Phone: (602) 795-6020

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

7500

Patient Label

Authorization for Release of Protected Health Information
Fax: 602-346-0591

I understand that The CORE Institute Specialty Hospital will not condition treatment on my signing this authorization. The CORE Institute Specialty Hospital will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form.

I also understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. For more details on when I can and cannot revoke this authorization, I can read The CORE Institute Specialty Hospital Notice of Privacy Practices.

To revoke my authorization, I must submit a written request to The CORE Institute Specialty Hospital. Unless I revoke the authorization earlier, this authorization will expire in one (1) year from date of signature unless another date is 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 that 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 _____ Date _____

Relationship to Patient _____

Upon completion of this Authorization, please send via fax to: 602-346-0591 or mail this form to:
The CORE Specialty Hospital
Health Information Management Department
6501 N 19th Avenue
Phoenix, AZ 85015
Phone: 602-795-6042