

Yuma Regional Medical Center • 2400 South Avenue A • Yuma, AZ 85364
Health Records Department • (928) 336-7017 • Fax (928) 336-7154
Consent to Release Protected Health Information

I authorize Yuma Regional Medical Center to disclose protected health information ("PHI") from the health records of:

Patient Name: _____ Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

I authorize YRMC to release PHI For service from _____ (date) to _____ (date) **OR** For this single event _____ (date).

Release To:

Self **Spouse (Name):** _____ **Dr. (Name):** _____ **Other:** _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone number: _____ Fax number: _____

Specific description of PHI to be disclosed:

Inpatient Visit – Date: _____

Complete Health Record – Starting Date: _____
(Excluding Genetic testing, Behavioral Health, Alcohol and/or Drug, and AIDS/HIV
unless authorized below)

unless authorized below)

Other: _____

Financial Records: _____

Emergency Room Visit – Date: _____

X-ray Report – Date: _____

X-ray Film or CD (available at X-ray Dept.)

Labs – Date: _____

I authorize the provider to use or disclose information related to:

All initial _____ **Or** only those checked:

Genetic Testing Information **initial** _____ Behavioral Health Care/Psychiatric Care/Mental Health Information **initial** _____

Alcohol and/or Drug Abuse Treatment **initial** _____ AIDS/HIV and other communicable diseases **initial** _____

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 sign this form. I may refuse to sign this authorization form.

I also understand that I may revoke this authorization at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read the Hospital's Notice of Privacy Practices.

To revoke my authorization, I must submit a written request to Health Records. Unless I revoke this authorization earlier, it will expire on the following date, event, or condition: Event: _____ **OR** Condition: _____

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 redisclosed 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. Hospital will retain copies of all authorizations for six years.

Signature of Patient

Date

Witness - YRMC Employee

Employee ID #

Signature of Legal Representative

Relationship to Patient or Description of Authority to Act for Patient

Section below to be completed when not witnessed by YRMC Employee

State of Arizona; County of Yuma

Subscribed and sworn (or affirmed) before me this _____ day of _____ 20 _____

Signature of Notary

Commission Expires

Hospital Use Only

MR # _____

Acct(s)# _____

ID ck'd by _____

Date released _____