AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Oasis Hospital

750 N. 40th Street, Phoenix, AZ 85008

Phone 602-797-7788 Fax: 602-797-7787

PATIENT'S NAME _____ BIRTHDATE _____

ADDRESS _____ ZIP _____ PHONE # _____

DATES OF HOSPITAL SERVICE _____

PURPOSE OF DISCLOSURE:

☐ Continuing Medical Care ☐ Legal Reasons ☐ Disability/Insurance ☐ Personal ☐ Inspection of Record

☐ Other:_____

RECORDS BEING REQUESTED:

☐ All Pertinent Reports ☐ Lab Reports ☐ Consultation ☐ Operative Report ☐ Discharge Summary ☐ Pathology Report

☐ EKG Reports ☐ X-Ray Reports ☐ History and Physical ☐ Other: Specify _____

☐ Billing Statement

I ACKNOWLEDGE, AND HEREBY CONSENT TO SUCH, THAT THE RELEASED INFORMATION MAY CONTAIN **CONFIDENTIAL HIV/AIDS RELATED INFORMATION, CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION, INFORMATION** RELATED TO **MENTAL HEALTH** AND/OR **ALCOHOL/DRUG USE**. _____(INITIAL)

I HEREBY AUTHORIZE: _____ TO RELEASE ALL OF THE ABOVE
COMPANY, PERSON, FACILITY

REQUESTED INFORMATION RELATIVE TO MY TREATMENT AND CARE TO: ☐ Mail ☐ Pick-Up (48 business hours)

_____
COMPANY, PERSON, FACILITY

_____ _____
ADDRESS PHONE

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 may refuse to sign this authorization. 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. To revoke my authorization, I must submit a written request to OASIS Hospital Health Information Management Department. This authorization shall be considered invalid after six months from the date on which it is signed. I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulation and may be redisclosed by the person or organization that receives the information. There may be a charge subject to reasonable charging rates .

_____ _____
SIGNATURE OF PATIENT* DATE

_____
SIGNATURE OF OTHER AUTHORIZED PERSON

_____
RELATIONSHIP TO PATIENT

* If patient is a minor and information is to be released regarding the treatment for alcohol or drug abuse, both the patient and parent or legal guardian must sign.

I affirm that the patient is deceased, that no personal representative of his estate has been appointed, and that I am the patient's _____.
REPRESENTATIVE

_____ _____
SIGNATURE DATE

HIMROI

O:A:S:I:S Hospital

PATIENT IDENTIFICATION LABEL

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100-017 (REV 2/17)