AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Oasis Hospital 750 N. 40th Street, Phoenix, AZ 85008

Phone 602-797-7780/7788 Fax: 602-797-7787 Email: SOSP_HIM@oasishospital.com

All (*) asterisks fields are required

PATIENT'S NAME* ______________________ DATE OF BIRTH* ______________ PHONE#* ______________

ADDRESS* ______________________ CITY/STATE* ______________________ ZIP* ____________

DATES OF HOSPITAL SERVICE* ____

PURPOSE OF DISCLOSURE*:

☐ Continuing Medical Care ☐ Personal ☐ Legal Purposes

☐ Disability/Insurance ☐ Inspection of Record

Other (please specify): ______________________________

RECORDS BEING REQUESTED*:

☐ All Pertinent Records ☐ History and Physical ☐ Lab Report

☐ Consultation ☐ Discharge Summary ☐ Operative Report

☐ Anesthesia Records ☐ Implant Record ☐ Pathology Report

☐ EKG Report ☐ Radiology Report ☐ Billing Statement

☐ Other (please specify): ______________________________

__________ **(INITIAL)*** 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.**

I HEREBY AUTHORIZE: **OASIS HOSPITAL** TO RELEASE ALL OF THE ABOVE REQUESTED INFORMATION RELATIVE TO MY TREATMENT AND CARE. IF REQUESTING FROM OTHER ENTITY PLEASE SPECIFY: ______________________________

DISCLOSING RECORDS TO*: ☐ Mail ☐ Pick-Up (48 business hours, ID Required) ☐ Fax (To a company/facility only)

____

(COMPANY, PERSON, FACILITY)

______________________________ ______________ ______________

(ADDRESS/CITY/STATE/ZIP CODE) (PHONE) (FAX)

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) (DATE)

____

(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 ______________________________. Please sign at the above authorized person line and state your relationship to the patient.

(REPRESENTATIVE)

HIMROI

H.I.M INTERNAL USE ONLY FOR RELEASE OF INFORMATION

Authorized Person ID checked ☐ Yes ☐ No Completed by (initials) ________

Shipped/Faxed/Picked-Up on date: ________________

PATIENT IDENTIFICATION LABEL

O:A:S:I:S Hospital

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100-017 (REV 3/20)