



## AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ SSN: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby authorize Gilbert Hospital, its directors, officers and employees to use or disclose the protected health information about the Patient identified above as described in this authorization.

1. The following person (or class of persons) may receive disclosure of the patient's protected health information:

Please choose from the following:

- ☐ Records to be picked up ☐ Records to be mailed ☐ Records to be released in a secure electronic format (excludes email)  
☐ Records to be faxed to a Care Provider; Please fill out the information below:

ATTN: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

2. The specific information that may be disclosed is (please give dates of service if possible):

Dates of Service: \_\_\_\_\_

- ☐ The most recent 6 months of pertinent information (ER chart, dictation, diagnostic imaging, labs, EKG)

- ☐ All medical records ☐ Other information (describe): \_\_\_\_\_

EXCLUDE the following information from the records release:

- ☐ HIV/AIDS information and other communicable diseases ☐ Drug or alcohol abuse treatment information  
☐ Genetic testing information ☐ Mental health treatment information

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by law.
4. I may revoke this authorization by notifying Gilbert Hospital's Privacy officer in writing of my desire to revoke it. Any exception to my right to revoke this authorization is included in Gilbert Hospital's Notice of Privacy Practices. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
5. I understand that my signature on this form is voluntary and that Gilbert Hospital will not condition treatment, payment, eligibility for benefits or enrollment on my decision to sign or not sign this form.
6. The purpose for which the disclosure is being made: \_\_\_\_\_  
☐ Continued patient care ☐ Personal use ☐ Worker's compensation  
☐ Insurance coverage or payment ☐ Attorney's office
7. This authorization expires on \_\_\_\_\_. If no date is indicated, this authorization will expire 90 days after the date of signature.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Signature of Patient or Patient's Representative \_\_\_\_\_

Date \_\_\_\_\_

If signed by someone other than the patient, state your relationship  
and your authority to act for the patient (if applicable)

Date \_\_\_\_\_

Gilbert Hospital

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DOB: \_\_\_\_\_  
ADMIT: \_\_\_\_\_  
ADM: \_\_\_\_\_  
MR #: \_\_\_\_\_

AGE: \_\_\_\_\_  
RM/BED: \_\_\_\_\_

HSV: \_\_\_\_\_  
SEX: \_\_\_\_\_  
/ \_\_\_\_\_  
#: \_\_\_\_\_  
PAT #: \_\_\_\_\_

