Internal Medicine
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Authorization to use or disclose protected health information

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name: _____ Date of Birth: _____ SS# _____
(Please print)

Address: _____ Phone: _____

Records are to be sent FROM:_____SUMMIT HEALTH CARE REGIONAL MEDICAL CENTER_____
Address: _____***2200 EAST SHOW LOW LAKE ROAD, SHOW LOW ARIZONA 85901***_____
Phone: _____(928) 537-4375_____ Fax: _____

Records are to be sent TO: _____
Address: _____
Phone: _____ Fax: _____

Purpose of request (please mark one of the following): Treatment Date(s): _____

_____ Permanent Transfer _____ Seasonal Transfer _____ Specialist
_____ Second Opinion __**XX**_ Primary Care Physician

The following information is to be disclosed: (Please check all that apply)

YES	NO	
_**X**_	___	Complete Record (includes all the BELOW information)
___	___	Physician's Notes- last 2 visits
___	___	Lab Results- last 2 years
___	___	Ultra Sounds/X-Ray *REPORTS*- last 2 years
___	___	MRI scans- last 5 years
___	___	Cardiac Studies- EKG, ECHO, STRESS
___	___	Other: _____

Sensitive information: I understand that the information in my records may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug use.
Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information may not be protected by federal confidentiality rules.
Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on the authorization.
Other Rights: (a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. HOWEVER, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. (b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.
Expiration: Unless otherwise revoked, this authorization will expire on the follow date, event or condition: _____
(If I do not specify an expiration date, event or condition, this authorization will expire in twelve (12) months.)

Signature of Patient or Legal Representative: _____

Date: _____ **PLEASE MAIL RECORDS IF MORE THAN 20 PAGES.**