DESERT SENITA
COMMUNITY HEALTH CENTER
Quality, Local, Affordable Health Care for All

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize **Desert Senita Community Health Center** to disclose the following information from the health record of:

PATIENT INFORMATION

Name: Date of Birth:

INFORMATION REQUESTED

☐ All Pertinent Records (includes all listed)	☐ History & Physical	☐ Discharge Instructions	☐ Billing Record	☐ ER Report
☐ Allergies	☐ Laboratory	☐ Assessments	☐ Photo	☐ Operative Report
☐ Consultation	☐ Medication List	☐ x-ray images	☐ Problem List	☐ EKG Report
	☐ Pathology Report	☐ Discharge Summary	☐ X-Ray Reports	

PURPOSE

☐ Self ☐ Continuing Medical Care ☐ Other(specify reason)

INFORMATION TO VIEWED or GIVEN TO

Company, Person, Facility: Phone: Fax:

ACKNOWLEDGEMENT

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/ Psychiatric Care, treatment of alcohol and/or drug abuse and genetic testing; my signature authorizes release of any such information.
I may refuse to sign this authorization form. I understand that Desert Senita will not condition or deny treatment on my signing this authorization.
I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken.
Desert Senita's Notice of Privacy Practices explains the process for revocation, which includes a request in writing.
Unless I revoke this authorization earlier, it will **expire 12 months** from the date signed or as specified:__/___/___
I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.
I release Desert Senita, its employees and agents, 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.

*_____
Signature of Patient Date:

In requesting the medical records as the designated agent, in signing below, I attest to the continuing inability of the above patient to make or communicate health care decisions.

*_____
Signature of Legal Representative Relationship to Patient or Description of Authority to Act for Patient Date:

For Healthcare Use Only:
Employee completed/reviewed form with patient:
Date Received:
Date Sent:
ID Verified:

Copy of Picture ID