



**BENSON
HOSPITAL**
PO Box 2290
Benson, AZ 85602
(520) 586-2261

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize _____
to disclose protected health information (PHI) from the health records of:

Patient Name: _____

Address: _____

Phone Number: _____

Birth date or Soc. Sec. #: _____

I authorize PHI from (date): _____ to (date) _____

to be disclosed to: _____

at: _____

Phone Number: _____

Fax Number: _____

Specify information to be disclosed:

- Discharge Summary
- History and Physical
- X-ray Reports
- Lab Tests
- Emergency Room Record
- Rehabilitation Records
- Other (specify): _____

I authorize the provider to use or disclose information related to:

- AIDS/HIV and other communicable diseases
- Behavioral Health / Psychiatric Care

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 this authorization form.



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I also understand that i may revoke this authorization at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read the hospital's Notice of Privacy Practices.

To revoke my authorization, I must submit a written request to the Health Information Department. Unless I revoke this authorization earlier, it will expire on the following date, event or condition _____.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re disclosed by the person or organization that receives the information.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, 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

Signature of Legal Representative

Date

Witness

Date