Benson Hospital
450 S. Ocotillo Ave., Benson, AZ 85602 (520)720-6520

Request for Records and/or Authorization to Use or Disclose Protected Health Information

I hereby authorize: Benson Hospital

If you have a disability that requires this authorization in an alternative format or require a special accommodation to complete this form, you may request assistance from staff at Benson Hospital or form the Privacy Officer @ (520)720-6522.

To Release Confidential Health Information To:

_____ (Recipient Name) _____ (Street Address)

_____ (City, State, Zip) _____ (Telephone Number) _____ (Fax Number)

From the medical record of:

Patient Name: _____ (First, Last) Date of Birth _____ (mm/dd/yyyy)

Social Security No: _____-_____-_____ Date(s) of Treatment: _____ (From/To)

Benson Hospital Patient Portal now available. Please provide your email address: _____

Information to be released:

- ☐ **Discharge Summary**
- ☐ **History & Physical Exam**
- ☐ **Operative Reports**
- ☐ **X-ray Reports**
- ☐ **Lab Tests**
- ☐ **Other (specify)**

The information specified is to be released for the following:

- ☐ **Continued Patient Care**
- ☐ **Workers Compensation**
- ☐ **Insurance Coverage or Payment for Care**
- ☐ **Attorneys request or trial proceedings**
- ☐ **The disclosure is at my (the patient's) request**
- ☐ **Other (specify)**

(If the client initiates the authorization and does not elect to provide a statement of purpose, then the statement "at the request of the individual" is adequate)

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

☐ YES – Okay to release ☐ No - Do not release

This authorization shall be considered invalid after six (6) months (or 60 days with respect to drug and alcohol abuse records) from the date of signing. Any records created after the date of this authorization will require a new authorization. I desire this authorization to be in effect until _____ (expiration date/event).

I also understand that I can revoke this authorization at any time, with some exceptions. To revoke my authorization, I must submit my request in writing to Benson Hospital Health Information Management (HIM). However, the undersigned may not revoke the authorization retroactively for information released.

I understand that this authorization is voluntary and I may refuse to sign this authorization.

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 understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal and state privacy regulations. I have a right to limit the information disclosed. I authorize Benson Hospital to use and disclose the protect health information as specified above.

I further understand that reasonable copy fee may be charged for reproduction of record copies and/or CD's. A copy or facsimile of this authorization is as valid as the original.

Preferred Method of Reproduction: ☐ Email ☐ Paper

If faxing or emailing this request, please include a legible copy of a valid driver's license

_____ _____ _____

Signature of Patient or Legal Representative Date Authority to sign if not Patient (Documentation may be required)

_____ _____ ____ Photo ID verified by Benson Hospital Employee

Signature of Witness/Benson Hospital Employee Date