Gila River Health Care (GRHC)

Hu Hu Kam Memorial Hospital, PO Box 38, Sacaton, AZ 85147 PH: 602-528-1399 Fax: 602-528-1255
Komatke Health Center, 17487 S Health Care Dr, Laveen, AZ 85339 PH: 520-550-6003 Fax: 520-550-6034
Ak-Chin Clinic, 48203 West Farrell Rd, Maricopa, AZ 85239 PH: 520-568-3881 Fax: 520-568-3884

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

1.

Name of Patient:	Chart #:
Address:	Date of Birth:

2. Information Released

FROM (✓ box)	**TO:** (✓ box)
☐ Hu Hu Kam Memorial Hospital ☐ Komatke Health Center ☐ Ak-Chin Clinic ☐ Other as identified below:	☐ Hu Hu Kam Memorial Hospital ☐ Komatke Health Center ☐ Ak-Chin Clinic ☐ Other as identified below:
Name of Person/Organization/Facility	Name of Person/Organization/Facility
Address	Address
City/State	City/State

3. The purpose or need for this release is: (✓ box)

☐ Medical Care ☐ School ☐ Attorney ☐ Disability ☐ Personal Use
☐ Insurance ☐ Transfer to new PCP ☐ Other:_____

4. The information to be released from my health record: *(✓ appropriate box(es))*

☐ Clinic Visits ☐ Physical Exam ☐ X-Ray CD (images) ☐ Lab Reports
☐ Immunization Record ☐ Billing ☐ Face Sheet ☐ X-Ray Reports
☐ Only information related to (Specify)_____
☐ **Only the period of events from:** _____ **to:**_____

➔ **If you would like any of the following sensitive information released**, ✓ **the applicable boxes**

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related treatment
☐ Sexually Transmitted Diseases ☐ Mental Health (Other than Psychotherapy Notes)
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving my psychotherapist-patient privilege)

5. I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event as identified here: _____. Specify New Date
Refer to GRHC's Notice of Privacy Practices for information concerning the right to revoke this authorization.

I hereby voluntarily authorize this release of information and understand that GRHCC will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for release to a third party.

I understand that information released by this authorization may be subject to re-release by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule of 1996 and the Privacy Act of 1974.

Signature of Patient, Guardian, or Legal Representative ***(State relationship to patient if applicable)***	**Date**

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552(a)(i)(3))

Tribal /State ID /Other: _____ID VERIFIED Employee Initials: _____Pages Given:____

