

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
Hau'pal Health Center 3042 W Queen Creek Road, Chandler, AZ 85286	PH: 520-796-2756	Fax: 520-796-2757
The Caring House P.O. Box 2187, Sacaton, AZ 85147	PH: 520-562-7400	Fax: 520-562-7453
Dialysis East - 565 Seed Farm Road, Sacaton, AZ 85147	PH: 602-271-7900	Fax: 602-271-7990
Dialysis West - 972 W Pecos Rd, Box 607, Laveen, AZ 85339	PH: 520-550-6052	Fax: 520-550-6051

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

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

2.	FROM (✓ box)		TO: (✓ box)	
	<input type="checkbox"/> Hu Hu Kam Memorial Hospital	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Hu Hu Kam Memorial Hospital	<input type="checkbox"/> Dialysis
	<input type="checkbox"/> Komatke Health Center	<input type="checkbox"/> Ak-Chin Clinic	<input type="checkbox"/> Komatke Health Center	<input type="checkbox"/> Ak-Chin Clinic
	<input type="checkbox"/> Hau'pal Health Center	<input type="checkbox"/> The Caring House	<input type="checkbox"/> Hau'pal Health Center	<input type="checkbox"/> The Caring House
	<input type="checkbox"/> Other as identified below:		<input type="checkbox"/> Other as identified below:	
	Name of Person/Organization/Facility		Name of Person/Organization/Facility	
Address		Address		
City/State		City/State		

Check this box if each of the parties listed above may disclose your information to, and receive your information from, the other party.

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: _____
 PHI to be used in a verbal discussion per HIPAA (only used for Healthcare Operations)

➔ **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 (not Psychotherapy notes) limited to the following: medication prescription and monitoring; counseling session start and stop times; modalities and frequencies of treatment furnished; results of clinical tests; and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

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
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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)(3))