

SIERRA VISTA REGIONAL MEDICAL CENTER

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:	_____
	Last First Middle
Home Address:	_____

Home Telephone:	_____
Date of Birth:	_____
Specify Information to be Disclosed:	

By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:	
<input type="checkbox"/> Mental Illness _____	
<input type="checkbox"/> Developmental Disability _____	
<input type="checkbox"/> Psychotherapy Notes _____	
<input type="checkbox"/> HIV/AIDS Testing, Diagnosis, or Treatment (regardless of result) _____	
<input type="checkbox"/> HIV Test Result _____	
<input type="checkbox"/> Communicable Disease _____	
<input type="checkbox"/> Substance Abuse, Prevention or Treatment _____	
<input type="checkbox"/> Sexual Assault _____	
<input type="checkbox"/> Child Abuse or Neglect _____	
<input type="checkbox"/> Genetic Testing _____	
<input type="checkbox"/> Domestic Abuse _____	
<input type="checkbox"/> Elder Abuse _____	
<input type="checkbox"/> Other _____	
RECIPIENT: Name of person or class of persons to whom Sierra Vista Regional Medical Center may disclose my health information:	

ADDRESS: Address of the recipient or where my health information should be delivered: _____	
TERM: This Authorization will remain in effect:	
<input type="checkbox"/> From the date of this Authorization until the ___ day of _____, 20__.	
<input type="checkbox"/> Until Sierra Vista Regional Medical Center fulfills this request.	
<input type="checkbox"/> Until the following event occurs _____	
<input type="checkbox"/> Other _____	

PURPOSE: I authorize **Sierra Vista Regional Medical Center** to use or disclose my health information (including the highly confidential I selected above, if any) during the term of this Authorization for the following specific purpose(s): Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization:

I understand that once **Sierra Vista Regional Medical Center** discloses my health information to the recipient, **Sierra Vista Regional Medical Center** cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable law governing the use and disclosure of my health information.

I understand that **Sierra Vista Regional Medical Center** may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may at any time make a written request to **Sierra Vista Regional Medical Center** to inspect and/or obtain a copy of my health information, and that **Sierra Vista Regional Medical Center** will either, within five days for a request to inspect and fifteen days for a request to copy, grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at **Sierra Vista Regional Medical Center**; except, however, if my treatment at **Sierra Vista Regional Medical Center** is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case **Sierra Vista Regional Medical Center** may refuse to treat me if I do not sign this Authorization.

I understand that, at any time during which this Authorization is in effect, I may make a written request to receive a copy of this Authorization. Such written request shall be made to **Sierra Vista Regional Medical Center's** Privacy Office at the address listed below.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to **Sierra Vista Regional Medical Center's** Privacy Office at the address listed below. The revocation will be effective immediately upon **Sierra Vista Regional Medical Center's** receipt of my written notice, except that the revocation will not have

