GILA REGIONAL Medical Center

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name (please print):	Date of Birth:
Address:	
Email:	Phone:

Entities Authorized to Use or Disclose Information: I hereby authorize Gila Regional Medical Center (GRMC) and its affiliated clinics, and personnel to use or disclose the Patient's protected health information as described below.

Information to be Disclosed (check all that apply):
Information concerning my healthcare that was rendered between the following dates: _____/_____/_____ to _____/_____/_____.

☐ Discharge Summary ☐ Laboratory Reports ☐ History and Physical ☐ Consultation
☐ Radiology Reports ☐ EKG Report ☐ Operative Reports ☐ Pathology Reports
☐ Radiology Images ☐ Clinic Reports ☐ Other (please specify) _____
☐ Billing and payment records for healthcare rendered during the relevant time period.

Patient understands that the information to be disclosed may contain sensitive information concerning drug and/or alcohol use or treatment, sexually transmitted diseases (STDs), HIV, mental health, or other sensitive health information.

Person or Organization to Whom the Information Should Be Disclosed:

Name of Person or Organization (please print):	
Address:	
Email:	Fax:
Deliver by: ☐ In-Person ☐ Mail ☐ Fax ☐ Secure Email	

Purpose for Use or Disclosure:
☐ At my request ☐ Legal ☐Other (please specify) _____

- I understand that I have the right to revoke this authorization at any time except to the extent that GRMC or its affiliated personnel have has taken action in reliance on this authorization. To revoke this authorization, I must submit a written notice to: **Gila Regional Medical Center, 1313 E 32nd St. Silver City, NM 88061.**
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment unless (1) the purpose for the Patient's evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or (2) the Patient is involved in research-related treatment and the use or disclosure is for such research.
- I understand that information described above may be re-disclosed by the entity who receives this information and may no longer be protected by privacy regulations.
- This authorization will expire on the following date: _____
  If no date is specified the authorization will expire in one (1) year.

If you have any questions about this Authorization, please contact the Health Information Management Department at 575-538-4108.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Signer (please print) Relationship of Signer to Patient

A copy of this signed Authorization will be provided to the Patient or Personal Representative unless the Authorization was initiated at the request of the Patient or Personal Representative.

FOR OFFICE USE ONLY:

Date Authorization Received:	Date Request Completed: