Northern Apache County Special Health Care District

St. Michaels Clinic • Sanders Clinic

Authorization for Release of Medical Information

Patient's Name:_____ DOB: _____ SS Number: XXX-XX-__ __ __ __

Address: _____ Male □ Female □

Name of Parent or Guardian (if child under 18 yrs of age): _____

Information to be disclosed to:

St. Michaels Clinic
P.O. Box 370 St. Michaels, AZ 86511

Phone: 928-810-3800
Fax: 928-810-3811

Information to be provided by:

Name:_____ Address: _____

Phone: _____ City/State_____ Zip Code: _____

Fax:_____

Reason or Purpose for disclosure:

□Further Medical Care □ Insurance □ School □Personal Use □Other:_____

Information to be disclosed from my health record:

□Entire Record □Immunizations □ Progress Notes *(dates requesting)*: _____

□ Other *(specify)* : _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the NACSHCD. I understand that the revocation will not apply to information that has already been released in response to this authorization. I unsterstand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition (not to exceed 90 days): If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date signed.

I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and Stated Regulations. I also understand that my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease.

By signing below you are voluntarily authorizing the disclosure of information from the selected health care record.

Patient Signature: _____

Parent or Guardian (Print): _____ Parent or Guardian Signature: _____

Relationship to patient: _____ Date: _____

Office Use Only

Form of Identification provided: _____ Date Completed: _____

Records prepared by: _____ □Mailed □Faxed □ Given to Patient/Parent

(Health Care Representative)

Northern Apache County Special Health Care District

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Address: _____ Male □ Female □

Name of Parent or Guardian (if child under 18 yrs of age): _____

Information to be disclosed to:

Sanders Clinic Phone: 928-688-3903

P.O. Box 489 Sanders, AZ 86512 Fax: 928-688-4471

Information to be provided by:

Name:_____ Address: _____

Phone: _____ City/State_____ Zip Code: _____

Fax:_____

Reason or Purpose for disclosure:

□Further Medical Care □ Insurance □ School □Personal Use □Other:_____

Information to be disclosed from my health record:

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Name:_____ Address: _____

Phone: _____ City/State_____ Zip Code: _____

Fax:_____

Information to be provided by:

Name:_____ Address: _____

Phone: _____ City/State_____ Zip Code: _____

Fax:_____

Reason or Purpose for disclosure:

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