

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	Phone: 928-810-3800		
P.O. Box 370 St. Michaels, AZ 86511	Fax: 928-810-3811		
Information to be provided by:			
Name:	Address:		
Phone:	City/State	Zi	p Code:
Fax:			
Reason or Purpose for disclosure:			
□Further Medical Care □ Insurance □ School	□Personal Use □Other:		
□ Other (specify): understand that I have a right to revoke this authorization at resent my written revocation to the NACSHCD. I understand esponse to this authorization. I unsterstand that the revocation he right to contest a claim under my policy. Unless otherwise not to exceed 90 days): If I fail to specify an expiration date, understand the information in my health record may include rederal and Stated Regulations. I also understand that my healt disease.	any time. I understand that if I revoked that the revocation will not apply to my insurance concervoked, this authorization will expense event or condition, this authorization will expense psychiatric, alcohol or drug abuse/tempsychiatric, alcohol or drug abuse/tempsychiatric, alcohol or drug abuse/tempsychiatric.	te this authorized information in mpany when the following will expire 9 testing information and the string informatics.	eation I must do so in writing and that has already been released in the law provides my insurer with the law provides my insurer wi
By signing below you are voluntarily authorizing the disclosure	re of information from the selected h	ealth care reco	ord.
Patient Signature:			
Parent or Guardian (Print):			
Relationship to patient:	Date:		
	Office Use Only		
Form of Identification provided:	Date Comple	ted:	
Records prepared by:	□Mailed □F	axed □ Give	en to Patient/Parent

(Health Care Representative)



Northern Apache County Special Health Care District

Authorization for Release of Medical Information

Patient's Name:	DOB:	SS Num	ber: XXX-XX
Address:		Male □	Female □
Name of Parent or Guardian (if child under 18 yr	rs 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:		Zi	p Code:
Fax:			
Reason or Purpose for disclosure:			
□Further Medical Care □ Insurance □	School □Personal Use □Other:		
understand that I have a right to revoke this authorizes my written revocation to the NACSHCD. It esponse to this authorization. I unsterstand that the right to contest a claim under my policy. Unless not to exceed 90 days): If I fail to specify an expire understand the information in my health record rederal and Stated Regulations. I also understand the disease.	prization at any time. I understand that if I refunderstand that the revocation will not apply to my insurance of the revocation will not apply to my insurance of the southerwise revoked, this authorization will pration date, event or condition, this authorization will not understand that the revocation will be revocation will be revocation.	ly to information e company when the expire on the follocation will expire 9 ase/testing information	that has already been released in the law provides my insurer with the wing date, event or condition to days from the date signed. The which may be protected be the signed of the which may be protected be determined.
By signing below you are voluntarily authorizing the	he disclosure of information from the selecte	ed health care reco	ord.
Patient Signature:			
Parent or Guardian (Print):	Parent or Guardia	n Signature:	
Relationship to patient:	Date:		
	Office Use Only		
Form of Identification provided:	Date Con	npleted:	
Records prepared by:	□Mailed	□Faxed □ Give	en to Patient/Parent

(Health Care Representative)



Northern Apache County Special Health Care District

St. Michaels Clinic • Sanders Clinic

Authorization for Release of Medical Information

Patient's Name:			
Address:			le Female
Information to be disclosed to:			
Name:	Address:		
Phone:			Zip Code:
Fax:			
Information to be provided by:			
Name:	Address:		
Phone:			Zip Code:
Fax:			
Reason or Purpose for disclosure:			
□Further Medical Care □ Insurance □ School	□Personal Use	□Other:	
□ Entire Record □ Immunizations □ Progress □ Other (specify): □ understand that I have a right to revoke this authorization a present my written revocation to the NACSHCD. I understate esponse to this authorization. I unsterstand that the revocate he right to contest a claim under my policy. Unless otherwise not to exceed 90 days): If I fail to specify an expiration dat understand the information in my health record may included and Stated Regulations. I also understand that my health sease.	at any time. I understand and that the revocation w tion will not apply to my se revoked, this authoriza te, event or condition, thi	that if I revoke this au ill not apply to inform insurance company vation will expire on the sauthorization will ex	athorization I must do so in writing and lation that has already been released in when the law provides my insurer with a following date, event or condition pire 90 days from the date signed.
By signing below you are voluntarily authorizing the disclos	sure of information from	the selected health car	re record.
Patient Signature:			
Parent or Guardian (Print):	Parent o	r Guardian Signatur	e:
Relationship to patient:	Date:		
	Office Use Only		
Form of Identification provided:		Date Completed:	
Records prepared by:(Health Care Representative)	,	□Mailed □Faxed □	☐ Given to Patient/Parent