UNITED COMMUNITY HEALTH CENTER, INC.

Authorization to Release Health Information

AMADO CLINIC
28720 S. NOGALES HIGHWAY
AMADO, AZ 85645
OFFICE – 520-407-5510
FAX – 520-407-5990

ARIVACA CLINIC
17388 W. 3RD. STREET
ARIVACA, AZ 85601
OFFICE - 520-407-5500
FAX – 520-407-5990

CONTINENTAL FAMILY MEDICAL CENTER
1260 S. CAMPBELL ROAD, BLDG 1
GREEN VALLEY, AZ 85614
OFFICE - 520-407-5900
FAX – 520-407-5990

CONTINENTAL PEDIATRICS CLINIC
1260 S. CAMPBELL ROAD
GREEN VALLEY, AZ 85614
OFFICE - 520-407-5800
FAX – 520-407-5990

FREEPORT MCMORAN COPPER & GOLD BUILDING
1260 S CAMPBELL ROAD BLDG 2
GREEN VALLEY, AZ 85614
OFFICE - 520-407-5400
FAX – 520-407-5990

SAHUARITA HEIGHTS CLINIC
2875 E. SAHUARITA RD.
SAHUARITA, AZ 85629
OFFICE – 520-576-5770
FAX – 520-407-5990

THREE POINTS CLINIC
15921 W. AJO WAY
TUCSON, AZ 85735
OFFICE - 520-407-5700
FAX – 520-407-5990

VAIL
OLD VAIL MIDDLE SCHOOL
13299 EAST COLOSSAL CAVE RD.
VAIL, AZ 85641
OFFICE – 520-762-5200
FAX- 520-407-5990

Patient Name: ___________________________ DOB: _____________ MR#:______________

Other Name(s) Used: __________________________________ SSN: ____________________

To:_______________________	**From:**_______________________
Address:_____________________________	Address:_____________________________
____________________________________	____________________________________
____________________________________	____________________________________
Ph:______________ Fax: _____________	Ph: _______________ Fax: ____________

I authorize the release and/or exchange of the following information on the person identified above.

___ Progress Notes ___ Health History ___ Medication Sheet ___ ER Report
___ Laboratory/Pathology ___ Radiology ___ EKG/EEG ___ Consultation
___ Discharge Summary ___ Immunization Record ___ My Complete Record
___ Other (specify) ____

*If you are authorizing limited release of your medical record, specify the date(s) of treatment and/or condition(s) ____

*In addition to the general authorization to release medical records, I further authorize the following information if it is contained in my record: (Must be initialed to authorize release)

_____ Drug/Substance Abuse _____ Diagnosis/treatment of HIV, HIV related illness.
_____ Mental Health ______ Sexually Transmitted Disease (STD)

With respect to drug/substance abuse treatment, or records regarding STD related information, the recipient of this information understands that it is prohibited from making any further disclosure without express written permission of the undersigned or otherwise as permitted by applicable law.

This information is requested for use by:

___ Medical Office/Health Care Facility ___ Attorney ___ Insurance Company
___ Personal Use ___ Other (Specify): _________________________

- I understand that I may revoke this authorization at any time, in writing, that the revocation will not apply to information that has already been released in response to this authorization, and that the authorization will automatically expire one year from the date of my signature.
- I understand that there may be a retrieval and copy charge associated with this release.
- I understand that only information dated prior to the date of this authorization may be released.
- I do not authorize further release by the receiving requestor to any third party, but I understand that once information is released pursuant to this authorization, the releasing facility or physician named above cannot prevent the rediclosure of that information.

Signature of Patient: ____________________________ Date: ____________________

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Signature of Authorized Person Date Relationship to Patient

Reason Patient Unable to Sign: ____________________ Witness: __________________