Cochise Regional Hospital

Authorization to Release Patient Information

Patient: _____ Date:_ _____ Time: _____

Name of Physician: _____

Name of Hospital: _____

Name of company or persons authorized to receive information:

_____

Dates of hospital confinement: _____ to _____

The following elements of patient's medical record are requested (please check all that apply):

☐ Entire Medical Record	☐ Medication List	☐ Physical Therapy Notes
☐ Demographic Information	☐ Immunizations	☐ Other (specify)
☐ History & Physical	☐ Test Results (Lab, XRay, etc)	☐ Other (specify)
☐ Medical/Surgical History	☐ Other Assessments	☐ Other (specify)
☐ Physician Office Visits	☐ Discharge Summary	☐ Other (specify)

Purpose of the records request (please check all that apply):

☐ Request of Individual	☐ Change of Doctor	☐ Legal
☐ Referral to Specialist	☐ Insurance	☐ Other (specify)
☐ Continuing Care	☐ Workers Comp	☐ Other (specify)

The undersigned hereby authorizes the above named hospital to provide the above named persons with a copy of any or all records, documents, reports, clinical abstracts, histories and charts, or every kind and description, relating to the above described hospitalization. It is understood that the copy of the records will be provided to the designated company or individual only upon payment of the reasonable charge for reproduction of the records. In furtherance of this authorization, I hereby waive all provisions of the law and privileges relating to the disclosures hereby authorized.

_____

Patient Signature

If the patient is unable to consent by reason of age or some other factor, state reasons:

_____

_____

_____
Witness

_____
Signature of Legally Authorized Representative

_____
Relationship to patient

_____
Contact Information: Phone/Fax

_____
Contact Information: Email

This request in being submitted by:

- ☐ Email: info@cochiseregionalhospital.org

Please confirm the information on which delivery method is preferred:

- ☐ USPS Mail: Complete Address must be provided below

  Name: _____

  Address: _____

  City / State / Zip Code: _____

- ☐ Fax: _____
- ☐ Email: _____