COBRE VALLEY
REGIONAL MEDICAL CENTER
5880 SOUTH HOSPITAL DRIVE
GLOBE, ARIZONA 85501
Phone (928) 425-3261 / Fax (928) 425-2960

Revised 10/13

If demographic information not competed by the computer above, please complete below

Authorization for Release of Medical Information

Medical Record # _____ Correspondence # _____ No of pages copied _____

THIS FORM MUST BE COMPLETED IN FULL

Patient Name: _____ Date of Birth: _____

I authorize and request that Cobre Valley Regional Medical Hospital release my records to:

_____

(Name of Person RECEIVING Medical Record Information)

_____

(Address of Person RECEIVING Medical Record Information)

Telephone Number of person RECEIVING the information including area code: (___) _____

Type of requested medical information: ☐ LABORATORY ☐ IMAGING ☐ ER ☐ PT ☐ EKG
☐ OTHER _____

Date of Service(s): _____

MEDICAL INFORMATION PERTINENT TO TREATMENT FOR THE FOLLOWING REQUIRE A SECOND PATIENT SIGNNATURE

☐ Alcohol
☐ Psychiatric Care
☐ Psychological Assessment and/ or Treatment
☐ Drug Testing
☐ HIV / AIDS Test Results and/or Treatments

Date of Service(s): _____

I the patient noted above understand what this information will be used for: ☐ Yes ☐ No

Patient comment: _____

NOTE: **Federal rules prohibit you from making any further disclosure of this information "unless further disclosure is expressly permitted by the "written consent of the person to who it pertains or is otherwise permitted by 42 CFR, part 2.**

Signature of Patient: _____ Date: _____

_____ _____
Signature of Patient's Legal Representative (if applicable) Relationship to Patient:

Witnessed by: _____ Date: _____