AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____

Healdsburg District Hospital Facility\Location Name

_____

Address

_____ _____

Phone Number Fax Number

Name of Patient: _____ Date of Birth _____

I hereby authorize the use and disclosure of protected health information about the above patient as follows:

A. COPIES FROM - Name of person, class of persons, or organization authorized to make the requested use or disclosure: _____
B. COPIES TO - Name of person, class of persons, or organization authorized to receive and use my protected health information: _____
_____
C. Description of patient's protected health information to be used or disclosed:
_____
_____
D. Patient's protected health information is being used or disclosed for the following purpose(s): _____
_____
[Attach additional pages, if necessary]

I understand that I have the following rights with respect to this Authorization:

1. The recipient of the protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law.
2. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits.
3. The Healdsburg District Hospital Facility named above will provide me with a copy of this Authorization if I request it.

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4. I may revoke this Authorization at any time by mailing or personally delivering a signed, written notice of revocation to the Healdsburg District Hospital Facility named on the top of the first page. Such revocation will be effective upon receipt, except to the extent that the recipient has taken action in reliance on this Authorization.

5. I am entitled to notice if any of the Healdsburg District Hospital Facilities will use or disclose the protected health information for marketing and receive payment for the use or disclosure of my protected health information.

This Authorization will expire in: One Year

Signature of Patient/Personal Representative*	Personal Representative's Authority to Act on Patient's Behalf
Printed Name	
Date	Address and Telephone Number of Patient/Personal Representative

*The "Personal Representative" is any of the following:

- For an incompetent adult:
  - A conservator of the patient's person
  - An agent appointed by the patient under a power of attorney for health care.
- For a minor who does not have special legal authority to sign an authorization:
  - Parent
  - Guardian
  - Any other person *in loco parentis*
- Any other individual who has the legal authority to make health care decisions on the patient's behalf (e.g., person who is the next-of-kin to a resident in a skilled nursing facility; person legally obligated to financially support patient); or
- An executor or administrator of the patient's estate or any beneficiary who stands to inherit property from the patient, if the patient is deceased

Physician following patient\Return copies to: _____