AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

NOTE: If you are a patient/patient representative requesting medical records for personal use, there may be a fee for production of the medical records.

EXPLANATION

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Name of Patient:	
Date of Birth:	Last four digits of SSN:
Current Address:	
Home #: Cell #:	Email:

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby Authorize:

☐ Healdsburg Hospital

To release my Medical Record to: ☐ Myself or ☐ Facility/Name below

Facility/Name:	Attention:
Address:	Phone:
City: State: Zip:	FAX:

Delivery Option: ☐ Mail to patient address ☐ Mail to Facility/Name ☐ Call when ready for pick-up: # _____

☐ Email: _____ @ _____ ☐ Fax to #: _____ or ☐ Electronic Media

INFORMATION TO BE RELEASED (Only check one box in this section)

Specify the Date(s) of treatment at the Hospital/Clinic: _____

☐ Pertinent Information: (This is what most patients and physicians need) Discharge Summary, Emergency Department Report, History and Physical, Consultations, Operative Reports, Labs, Radiology Reports, EEG, EMG, EKG, Pathology Reports.

OR ☐ Entire Medical Record

OR ☐ Only the following records or types of health information: _____

Radiology/Imaging CD Requests Only. ☐ (CD requests for Healdsburg Hospital need to be submitted directly to the Radiology/Imaging departments at the hospital)

AUTHORIZATION TO RELEASE STATUTORILY PROTECTED INFORMATION

I specifically authorize release of the following information (Initial and Date as appropriate):

Mental health treatment information	Initial and Date:
HIV test results	Initial and Date:
Alcohol/drug treatment information	Initial and Date:

PURPOSE

Purpose of requested use or disclosure: ☐ Patient Request ☐ Continuing Care ☐ Legal ☐ Insurance

☐ Other: _____

EXPIRATION

This authorization expires (Date): _____

If no Date is given; this authorization will expire 6 months from the signature date.

MY RIGHTS

I may refuse to sign this authorization. If I refuse to sign this authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to Santa Rosa Memorial Hospital or Petaluma Valley Hospital, listed below.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE

Patient Signature: _____ Date: _____

Legal Representative Signature: _____ Date: _____
(Patient representative) Please Print Name: _____

If signed by someone other than the patient, state your legal relationship to the patient and why you have the authority to act for the patient: _____

To release mental health records we must obtain authorization from the physician who attended the patient during their stay and must be treated as confidential under State Regulation (Welfare & Institutions Code 5328).

SUBMIT REQUEST TO:

HEALDSBURG HOSPITAL
ATTN: HEALTH INFORMATION MANAGEMENT DEPT.
ADDRESS: 1375 University Ave
Healdsburg, CA 95448
PHONE: (707) 431-6470
FAX: (707) 431-6466
EMAIL: 365-CA-HH-medrecrequests@providence.org
WEBSITE: healdsburghospital.org

HOSPITAL USE ONLY

PHYSICIAN RELEASE OF MEDICAL RECORD

☐ APPROVED By Physician Name: _____ Date: _____ HIM Staff initials: _____

☐ DENIED - REASON FOR DENIAL: _____

MD Signature: _____ Date: _____ Time: _____

Request completed by hospital staff: _____ Date: _____