MR#:________________ DOS:____________ ACCT#:__________________

USE AND DISCLOSURE OF PROTECTED 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.

Name of Patient:______________________________ Other Names Used:______________________________

Date of Birth: ________________ Phone #: __________________ Expiration date of authorization ____________ (mm/dd/yr max 2yrs)

I AUTHORIZE:______________________________ at the following address: ______________________________ (street, city, state and zip code)

TO DISCLOSE TO:___________________________ at the following address: ______________________________ (street, city, state and zip code)

Phone #: ____________________ Fax #: __________________

❑ Patient pickup ❑ Mail ❑ Fax ❑ Review Only ❑CD ** There may be fees associated with your request

the following information contained in the records specified below (check box and initial applicable lines below):

- ❑ Mental health or developmental disability treatment records (excludes "psychotherapy notes")
- ❑ Substance abuse treatment records
- ❑ HIV test results (This authorizes disclosure of laboratory test results only. **Note that your records may include information concerning your HIV status even if you do not initial this line.)**

❑ **Billing Records only**

❑ **ALL RECORDS** regarding my treatment, hospitalization, and outpatient care.
A separate authorization is required for the use or disclosure of psychotherapy notes or research health information.

❑ THE FOLLOWING RECORDS, specific types of health information, or records for the date(s) of treatment as specified [check applicable box(es):]

❑ Emergency Room ❑ Radiology ❑ Laboratory Tests ❑ Dictated Reports (ie; Discharge Summary, Op Report)

❑ Date(s) of service: ____

MY RIGHTS: (see privacy rule, 45 C.F.R. § 164.508 (c)(2))

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:
  HIM DEPT - Mark Twain Medical Center, 768 Mountain Ranch Road, San Andreas, CA 95249.
  My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I understand that my information may be re-disclosed by the recipient and may be no longer be protected the Privacy Rule.

I would like a copy of this authorization. ❑ **Yes** ❑ **No**

Signature:______________________________ Date: ______________________________

______________________________ ______________________________
Print name of personal representative Relationship to patient

Office Use Only:
Patient/Representative Identification Verified. *Initials/Dept:* ______/______

❑ Patient Pick-up ❑ Faxed
❑ Mailed ❑ Health Port ref#__________
❑ Informed patient of charges that may apply

768 Mountain Ranch Road
San Andreas, CA 95249
(209) 754-3521

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (Rev 04/15)