Dignity Health Medical Group®
A Service of Dignity Health Medical Foundation

# AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

**I authorize** _____
(name of physician or health care provider authorized to use or disclose information)

**Dignity Health Medical Group-Golden Empire Cardiology Fax 661-321-3166 phone 661-321-3161**
3838 San Dimas St, Ste B201, Bakersfield, CA 93301

**To furnish to** _____

**Health information described below on:** _____
(Patient name)

**For the purpose of:** _____

**This information is limited to the following type and amount of information. (Use dates where appropriate).**

- ☐ Progress Notes
- ☐ Consultation Reports
- ☐ Laboratory, Pathology Reports from_____ to _____
- ☐ Radiology Reports/Imaging Reports from_____ to _____
- ☐ Other: _____

I understand that I have a right to revoke this authorization at any time. I understand that my revocation must be in writing and presented to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date event or condition:

_____

If I fail to specify an expiration date, event or condition, ***this authorization will expire in six months.***

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information. I understand I have a right to receive a copy of this authorization.

_____ _____
Signature of Patient, Parent or Legal Guardian Patient Date of Birth

_____
If signed by other than patient, indicate authority to sign

_____ _____
Witness signature Date

Patient has an appointment on: _____