

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

