A Service of Dignity Health Medical Foundation
Mercy Medical Group

Release of Medical Information
10995 Gold Center Drive, Suite 290
Rancho Cordova, CA 95670
Phone: (916) 363-4040 Fax: (916) 366-3662
Email: GSSA-ROI@Dignityhealth.org

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Note: Fee may apply to certain requests, and records will be processed within 15 business days

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.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient: _____ **Date of Birth**: _____

Other Names Used: _____ **Medical Record #**: _____

Patient Address: _____

(Street, City, State and Zip Code)

Phone Number #_____ **Email:**_____

I AUTHORIZE: **DIGNITY HEALTH MEDICAL FOUNDATION**

(Facility and name of the provider)

TO DISCLOSE TO: _____

(Persons/organizations authorized to receive the information) at the following address:_____

(Street, City, State and Zip Code)

Phone: _____ **Fax Number:** _____ **Email:** _____

SELECT METHOD FOR DELIVERY (PLEASE SELECT ONE OPTION)

- ❑ Mail *(at address listed above)*
- ❑ Fax *(at number listed above)*
- ❑ Flash Drive (*(PDF file), provided to you via secure flash drive)*
- ❑ Electronic Copy (*provided to you via Dignity Health's Secure Email Messaging service)*, the following information is required:

*For electronic delivery of your health record, please provide **related**) in the space provided. Your **personal email address (non-work)***

Email Address_____@_____

Please acknowledge this address is yours and accurate with your signature in the space provided

Signature: _____

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❑ **SPECIAL ACKNOWLEDGEMENT (PHYSICIAN APPROVAL NEEDED)**

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

____Mental health or developmental disability treatment records (excludes "Psychotherapy notes")

____ Genetic testing

____Substance abuse treatment records.

____STD (sexual transmitted disease)

____HIV test results (This authorizes disclosure of laboratory test results only.

Note that your records may include information concerning your HIV status <u>even</u> if you do not initial this line.)

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

__History & Physical __Progress Reports __Radiology Reports

__Consultations __Procedure Reports __Laboratory Tests __ Immunization Record

__Date(s):_____

Enter date range or Date(s) of record to be released

__Other:_____

❑ **ALL RECORDS** regarding my treatment, and outpatient care. A separate authorization is required for the use or disclosure of psychotherapy notes or research health information. Last two years Clinic records will be released.

Note: A different authorization form needs to be completed for Hospital Record (916-854-2000), Radiology Imaging (916-733-3301), and Billing Record (916-379-2804). Please contact them to get their authorization form, and fax number.

PURPOSE: The purpose and limitations (if any) of the requested use or disclosure is:

___At the request of the patient or personal representative; ***OR*** Continuity of Care: _____ Insurance: _____Other:_____

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified: _____

(Insert Date on which you want to revoke this authorization)

MY RIGHTS:

- 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: ***<u>Attn: Dignity Health Medical Foundation 10995 Gold Center</u>***

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Drive, Suite 290, Rancho Cordova, CA 95670. 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.

DISCLOSURE

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). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

SIGNATURE: _____ **DATE:**_____

(Patient or personal representative)

_____ _____

(***Print name of personal representative)*** ***(Relationship to patient)***

Note: If the **substance abuse treatment** information is protected by federal confidentiality rules (42 C.F.R. part 2) the following prohibition of re-disclosure statements must be provided to the recipient of the information:

The federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Office use only: Identifications verified by (Name) _____
Verified Method: _____ Photo ID _____Matching Signature _____Others