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 <u>even</u> 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

Dignity Health.
Mark Twain Medical Center

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

* R O I *

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