AUTHORIZATION FOR DISCLOSURE OR USE OF MEDICAL INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Patient Name:	Date of Birth:	Phone #	
Address:	City	State	Zip

Disclosure and Use of Health Information

I Hereby Authorize:

☐ Salinas Valley Memorial Hospital
☐ Taylor Farms Family Health and Wellness Center
☐ Other: _____

To Release my Health Information to:

_____
Name of Person/Organizations Authorized to Receive the Information

_____
Address, Street, City, State, Zip

Information To Be Released:

A. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received; OR

☐ Only the following records or types of health information (including any dates):
_____

☐ Complete Health Records
☐ History & Physical Examination
☐ Consultation Reports
☐ X-Ray Reports
☐ Discharge Summary
☐ Progress Notes
☐ Laboratory Test
☐ Photographs, Videotapes
☐ Digital or Other Images
☐ Other (please specify): _____

B. I specifically authorize release of the following information (check as appropriate):

☐ HIV tests results _____(initial)

☐ Alcohol / Drug / Mental Health treatment information _____(initial)

Salinas Valley Memorial Healthcare System
450 East Romie Lane, Salinas, CA 93901
(831) 757-4333 • Toll free (888) 755-7864

HIMROI

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8700-015379 (Rev. 9/17)

ORIGINAL - Chart

PLACE PATIENT LABEL HERE
Med. Rec.: #
Acct. #:

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PURPOSE

Purpose of requested disclosure or use: ☐ Patient request

☐ Other: _____

_____

Limitations, if any: _____

_____

Expiration Date

This authorization expires one year from date signed. If you chose a different date please specify: _____

_____

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 inspect or obtain a copy of the health information that I am being asked to allow the disclosure or use of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: HIM Department, 450 Romie Lane, Salinas, CA 93901.
  My revocation will take effect upon receipt, except to the extent that others have already acted upon this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

Patient to receive a copy of this authorization: ☐ Received copy ☐ Refused copy

_____

Signature: _____ Date _____ Time _____ am/pm
(patient / legal representative)

If signed by a person other than the patient, indicate relationship: _____

Print name: _____
(legal representative)