



Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: () _____ Alternate Phone: () _____

DOB: _____ Last 4 Digits of SSN: _____

I hereby authorize _____ (Name of physician, hospital or health care provider) to disclose to:

Name of Requestor: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: () _____ Fax:() _____

Purpose of requested disclosure:

Medical Care Personal Other: _____

Date of Service: _____

This authorization applies to the following information:

- History and Physical Dialysis Records
 Discharge Summary Labs/X-Rays
 Mental Health Treatment Info HIV Treatment
 Operative Report Alcohol/Drug Treatment
 Emergency Department Report
 Genetic Information
 Other: _____

Method of Release:

Pick up by Patient: Paper CD

Pick up by other than patient:

Name: _____

If emailed to patient, email address: _____

EXPIRATION

This authorization expires (insert date): _____

Patient Label



NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this authorization. I have the right to receive a copy of this authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address:

Madera Community Hospital
Health Information Management
1250 E. Almond Ave.
Madera, CA 93637

My revocation will be effective upon receipt, but will be limited to the extent that the requestor or others may have responded to this authorization.

Neither treatment, payment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might 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.

I may inspect or obtain a copy of the health information that I am being asked to authorize use or disclosure.

I understand that this may include ALL medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition, including psychological or psychiatric impairment, drug abuse and/or alcoholism, and HIV results.

If this box is checked, the requestor will receive compensation for the use or disclosure of my information.

SIGNATURE

Patient: _____	Signature: _____	Date/Time: _____
<input type="checkbox"/> Signed by other due to patient's condition at time of service		
Other's Signature: _____	Date/Time: _____	Relationship: _____

Attending must authorize release of Psychiatric and Chemical Dependency records:

Please check one: Authorize Release Deny Release

			am / pm
Physician	Signature	Physician #	Date/Time

Patient Label