MADERA COMMUNITY HOSPITAL
1250 E. Almond Ave. • Madera • CA 93637
(559) 675-5555 • MaderaHospital.org

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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: _____ M#_____

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/V#: _____

This authorization applies to the following information:

☐ History and Physical
☐ Discharge Summary
☐ Operative Report(s)
☐ Consultation Report(s)
☐ Emergency Department Report
☐ Pathology Report
☐ Labs / X-rays
☐ Other: _____

METHOD OF RELEASE:

☐ Paper X-ray images : ☐ CD ☐ QR code

☐ Pick up by Patient ☐ Pick up by other than patient: [PRINT NAME] _____

ALL ALLOWABLE CHARGES MUST BE PAID PRIOR TO MAILED RECORDS

EXPIRATION

This authorization expires (insert date): _____

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 befaalf and delivered to the following address: Madera Community Hospital, ATTN: Health Information Management, 1250 E. Almond Avenue, 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. Treatment, payment or eligibility for benefits will **not** be conditioned on my providing or refusing to provide this authorization.

I UNDERSTAND THAT THIS AUTHORIZATION:

1. California law prohibits further use or disclosure of the information being released beyond the specified limits of this consent unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law;
2. Patient health information may be subject to re-disclosure by the recipient and will no longer be protected by Federal confidentiality laws (HIPAA);
3. Includes *ALL* medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition, **including psychological or pschaiatric impairment, drug abuse and/or alcoholism, or Acquired Immunodeficiency Sydndrome (AIDS), or test for, or Infection with Human Immunodeficiency Virus (HIV);**
4. I may inspect or obtain a copy of the health information that I am being asked to authorize us or disclosure.

SIGNATURE:

Patient: _____ Signature: _____

Date / Time: _____

☐ Signed by other due to patient's condition at time of service

Other's Signature: _____ Relationship: _____

Printed Name: _____ Date / Time: _____

Attending must authorize release of Psychiatric and Chemical Dependency reports:

PLEASE CHECK ONE: ☐ Authorize Release ☐ Deny Release

Physician: _____ Signature: _____

Physician #: _____ Date / Time: _____ a.m./p.m.

ALL ALLOWABLE CHARGES MUST BE PAID PRIOR TO MAILED RECORDS