



**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 MADERA COMMUNITY HOSPITAL [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:

- |   |  |
|---|--|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Emergency Department Report |
| <input type="checkbox"/> Discharge Summary    | <input type="checkbox"/> Pathology Report            |
| <input type="checkbox"/> Operative Report     | <input type="checkbox"/> Labs / X-rays               |
| <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Other: _____                |

**METHOD OF RELEASE:**

- Pick up by Patient     Paper     CD  
 Pick up by other than patient [PRINT NAME] \_\_\_\_\_

**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 behalf 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 specific 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 psychiatric impairment, drug abuse and/or alcoholism, or Acquired Immunodeficiency Syndrome (AIDS), or tests 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 use or disclosure.

**SIGNATURE**

Patient: _____	Signature: _____
Date / Time: _____	
<input type="checkbox"/> 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