



## AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Date(s) of Service: \_\_\_\_\_

I authorize: \_\_\_\_\_

To release to: \_\_\_\_\_

Name of recipient

\_\_\_\_\_  
Street City State Zip

\_\_\_\_\_  
Fax number

\_\_\_\_\_  
Phone number

The following health information:

- |  |  |
|--|--|
| <input type="checkbox"/> Discharge Summary         | <input type="checkbox"/> Pathology Report(s)       |
| <input type="checkbox"/> History & Physical        | <input type="checkbox"/> EKG Report(s)             |
| <input type="checkbox"/> Consultation Report       | <input type="checkbox"/> Echocardiogram Report(s)  |
| <input type="checkbox"/> Operative Report          | <input type="checkbox"/> Immunization Records      |
| <input type="checkbox"/> Inpatient Progress Notes  | <input type="checkbox"/> Same Day Surgery Record   |
| <input type="checkbox"/> Outpatient Clinic Records | <input type="checkbox"/> Complete Medical Record   |
| <input type="checkbox"/> Emergency Record          | <input type="checkbox"/> Radiology Images (x-rays) |
| <input type="checkbox"/> Laboratory Test(s)        | <input type="checkbox"/> Other: _____              |
| <input type="checkbox"/> Radiology Report(s)       |  |

Please include restricted access information relating to (*initial if needed*):

\_\_\_\_\_ HIV test results      \_\_\_\_\_ Substance abuse

\_\_\_\_\_ Mental Health      \_\_\_\_\_ Genetic testing

The recipient may use my health information only for the following purpose(s): \_\_\_\_\_

**EXPIRATION:** This authorization shall become effective immediately and shall remain in effect for one year from the date signed unless a different date is specified here: \_\_\_\_\_

**RESTRICTIONS:** California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

**YOUR RIGHTS:**

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address: \_\_\_\_\_
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have a right to receive a copy of this authorization (required if authorization is requested for the provider’s use or disclosure of health information).
- I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.
- If this box  is checked Mills-Peninsula Health Services will receive compensation for the use or disclosure of my health information.

**SIGNATURE:**

\_\_\_\_\_  
Date                      Time                      Signature (Patient/Representative)

If signed by other than patient, print name and relationship

\_\_\_\_\_  
Name                                      Relationship

Witnesses (2) only required for telephone consent, physical inability to sign, or signature by mark:

\_\_\_\_\_  
Date              Time              Witness              Witness