

MAYERS MEMORIAL HOSPITAL DISTRICT

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH 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.

Name of patient: _____ Date of Birth _____ MRN _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Mayers Memorial Hospital District to release to: _____

(Persons/Organizations authorized to receive the information)

(Address — street, city, state, zip code)

The following information:

- 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):

- B. I specifically authorize release of the following information (check as appropriate):
 Mental health treatment information (initial)
 HIV test results (initial)
 Alcohol/drug treatment information (initial)

A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.

PURPOSE

Purpose of requested use or disclosure: Patient request; OR Other:

Limitations, if any: _____

MAYERS MEMORIAL HOSPITAL DISTRICT

EXPIRATION

This authorization expires on (*date*): _____

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.²
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing³ and submit it to the following address: _____
- My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.⁴
- 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.

SIGNATURE

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

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

Print name: _____ Phone number: _____
(legal representative)

Contact Phone Number: _____