Alta Bates Summit Medical Center
A Sutter Health Affiliate

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Explanation

This authorization for use or disclosure of my health information is required by state and federal law. Failure to provide all information requested may invalidate this authorization.

Authorization

I hereby authorize the use or disclosure of my health information as follows:

☐ Summit Campus

_____

is authorized to use or disclose, and (enter name of recipient) _____

_____

Address Street City State Zip Phone

is authorized to receive my information.

This authorization applies to the following information pertaining to any medical history, mental, chemical dependency, or physical condition and treatment received.

☐ Provide only the following records or types of records (provide treatment dates):

_____

_____

_____

☐ All of my records from (enter dates) _____
(Note: HIV test results require a special authorization)

The recipient may use my health information only for the following purposes: (not required when patient is the recipient)

_____

Expiration

This authorization expires (enter date) _____

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:

For the Ashby/Herrick Campus.

For the Summit Campus:
Summit Medical Center
Health Information Services/ROI Unit
350 Hawthorne St.
Oakland, CA 94609

• 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.

If this box ☐ is checked, copy was requested and received. Initials _____

• I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.

• If this box ☐ is checked, ABSMC will receive compensation for the use or disclosure of my health information.

Patient Name (print name) _____ Date of Birth _____

Other names used: _____

Your Signature _____ Date _____

Patient/Personal
Representative Signature _____

Relationship to Patient: _____

Witness _____

Authorized Agent:
Knox Attorney Service, Inc., Knox Services LLC.

Authorized Agent:
Knox Attorney Service , Inc./ Knox Services LLC.