JOHN MUIR/MT. DIABLO HEALTH NETWORK
John Muir / Mt. Diablo Health System

John Muir Family and Immediate Care
1455 Montego #205
Walnut Creek, Ca 94598
Phone: (925) 939-4444 Fax: (925) 939-5010

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information, about you Failure to provide *all* information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____

to release to: _____

_____

(Persons/Organizations authorized to *receive* the information) (Address-street, city, state, zip code) the following information:

Yes ☐ No ☐ All records Dates: From _____ TO _____

If no to all records, please specify which records are to be withheld

- ☐ Mental health treatment information
- ☐ HIV test results
- ☐ Drug/Alcohol treatment information

OR

Yes ☐ No ☐ Only those records pertaining to specific medical data (ie Motor Vehicle accident, immunizations, etc.) Dates: From _____ TO _____

Specify: _____

_____

_____

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

Please Note: In the event that this office is contacted by your Life/Health/Disability insurance company to release your medical record, you are forfeiting, the confidentiality of your Protected Health Information (PHI).

The insurance company's interpretation of your health may not always coincide with your physicians' opinion of your overall medical health, which may adversely affect your insurance coverage.

PURPOSE

Purpose of requested use or disclosure: ☐ personal files ☐ changing providers ☐ moving OR ☐ other: (please specify purpose below)

EXPIRATION

This authorization will expire 30 days from the date signed unless otherwise stated.

_____ Expiration 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. However, my refusal may hinder the release of records to the requester.

I may inspect or obtain a copy of the health information that I am begin asked to allow the use or disclosure of.

I have a right to receive a copy of this authorization.

I may revoke this authorization at any time, but I must do so in writing and submit it to the office address where this authorization was originally submitted.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE

Date: _____ Phone Number: _____ Time: _____ am/pm

Printed Name: _____ Date of Birth: _____

Signature: _____
(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:

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