# SIERRA VISTA HOSPITAL
# AUTHORIZATION TO USE OR RELEASE PROTECTED HEALTH INFORMATION

**FOR THE RECIPIENT OF THE INFORMATION:**

If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

***NOTE: California Law also prohibits further disclosure of medical information, including alcohol or drug abuse treatment records and medical and/or mental health records,*** unless further use or disclosure is expressly permitted by obtaining a new written authorization for release of information from the person to whom the information pertains.

I hereby authorize: SIERRA VISTA HOSPITAL
8001 Bruceville Rd.
Sacramento, CA 95823 (916) 423-2000

To use or release health information and records obtained during the course of treatment of:

Patient Name: ______________________ Date of Birth: ______________________

Address: ______________________ Patient/Requester's Phone: ______________

______________________ Social Security No.: ______________

1. The information is to be used or disclosed to the following persons or organizations:

   Person/Entity Name: ______________________ Phone: ______________

   Address: ______________________________________

2. Purpose: ☐ At the request of the patient ☐ Other: ______________________

3. The information to be used or disclosed includes only those items checked below, with respect to services provided on or around (insert dates of service): ______________________. If this line is left blank, the treatment dates covered by this authorization are from the most recent preadmission to discharge and claims resolution.

I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnoses. The information to be used or released includes:

_____ Discharge Summary
_____ Psychological Testing
_____ Laboratory Data
_____ Medication Records
_____ Administrative Letters (i.e., dates of stay, physician, Dx)
_____ History and Physical Exam
_____ Treatment Plans
_____ X-ray Report
_____ Assessments
_____ Verbal Communication with:
_____ Psychiatric Evaluation
_____ Progress Notes
_____ Consultation Reports
_____ Billing/Financial Records

_____ All Records

Name: ______________________

Relationship: ______________________



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

Patient's Name ________________________________

This authorization is limited to only that information that I have requested above to be used or disclosed to the persons/facilities named herein. I hereby release Sierra Vista Hospital from all legal responsibilities or liability that may arise from the use or disclosure of medical records and other health information in reliance on this authorization.

1. **Expiration:** I understand that unless I revoke the authorization earlier, this authorization will automatically expire 180 days from the date this authorization is signed.
2. **Re-disclosure:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or redisclosed by the receiving party.
3. **Refusal to sign:** I understand that I may refuse to sign this authorization and that Sierra Vista Hospital will not condition treatment, payment, or eligibility for benefits on whether I sign this authorization.
4. **Certification:** I certify that I am (check whichever applies):
   - ☐ The patient, and the identification that I have provided is true and correct.
   - ☐ The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: ________________________________".
5. **Revocation:** I have the right to make a written request to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.
6. **Copy:** I understand that I will receive a copy of this authorization.
7. **Minors:** I understand that minors over 14 years of age must sign the authorization along with their parent/guardian.

________________________________ ________________
(Patient Signature) (Date)

________________________________ ________________
(Parent/Guardian) (Date)

________________________ ________________________ ________________
Staff Member/Witness Signature (Print Last Name) (Date)

**(INTERNAL USE ONLY)**

☐ I have verified the patient's signature against the medical record.

☐ I have received ________________________________ as documentation that verifies the relationship with the patient and the authority to request/receive health information on behalf of the patient.

________________ ________________________ ________________________
(Date) (Employee Initials / Title) (Department)

Original: Medical Record Copy: Patient or Patient's Representative *(Required)*



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