AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient
Name _____ DOB _____ MR# _____

Type of Access Requested: | Copies Inspection _ Other _____

Authorization

I hereby authorize _____ to use and/or disclose my health information
name of hospital, physician, health care provider

to: _____
name of individual, organization, etc.

_____
address city state zip

Purpose of disclosing information: _____

This authorization applies to the following information:

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

	Date		Date
	H & P		Special Tests
_	Discharge Summary		Lab/X-ray
	Consultation		ER Records
_	Outpatient Records		Other

OR

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

I understand that the information in my health record may include information relating to sexually transmitted disease, or acquired immunodeficiency syndrome (AIDS). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Expiration

This authorization will expire on (enter date or event) _____or six months from the date of execution.

Sutter Health
Sacramento Sierra Region

SAFH SDH _| SMCS SRMC

Authorization for Use or Disclosure of Health Information

20650 (12/17/03)

Patient Identification

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

California 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, payment or health plan enrollment or eligibility for benefits.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to Health Information Services Department at this facility.
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.

Redisclosure

I understand that if the recipient of my information is not a healthcare provider, a health plan or healthcare clearing house, or not an entity required to comply with federal or state health privacy regulations, my health information may be further disclosed by such recipient and my information may no longer be protected by state and federal laws.

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

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

Phone#: Day _____ Message _____

Patient Signature _____ Date _____

Personal Representative Signature _____

Relationship to Patient _____

Witness _____

ATTENTION RECIPIENT: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE.