TWIN CITIES COMMUNITY HOSPITAL
1100 Las Tablas Road
Templeton, CA 93465
805 434-4516 Telephone/ 805 434-4586 Facsimile

Note to Requestor of Records:
There may be a charge for copies of the medical record.

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Medical Record/Acct#_____

Patient's Name: _____
Last First Middle

Home Address: _____

Home Telephone: _____ Date of Birth: _____

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes:

☐ Abstract (face sheet, discharge summary, history & physical, consultation, operative report) ☐ ED report

☐ Test Results (lab, x-ray, cardiology, EKG) ☐ Surgical (operative/pathology report) ☐ Other _____

DATE(S) OF TREATMENT: _____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about mental health or mental retardation services
☐ Psychotherapy Notes created by a mental health professional
☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ Information about sexually transmitted diseases
☐ Information about alcohol or drug abuse treatment program services
☐ Information about sexual assault
☐ Information about child abuse and neglect

NAME OR CLASS OF PERSONS RECEIVING INFORMATION:

Name: _____ **Phone No.:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

TERM: This Authorization will remain in effect:

☐ From the date of this Authorization until the _____ day of _____, 200__.

☐ Until Twin Cities Community Hospital fulfills this request.

☐ Other: _____.

PURPOSE: I authorize Twin Cities Community Hospital to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s):

☐ Personal ☐ New Physician ☐ Primary Care Physician ☐ Social Security Disability

☐ Medical Ins. Claim ☐ Life Insurance ☐ Workers' Comp ☐ Attorney

☐ Other _____

I understand that once Twin Cities Community Hospital discloses my health information to the recipient, Twin Cities Community Hospital cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and California law governing the use and disclosure of my health information.

I understand that Twin Cities Community Hospital may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Twin Cities Community Hospital; except, however, if my treatment at Twin Cities Community Hospital is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Twin Cities Community Hospital may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Twin Cities Community Hospital's Privacy Office at the address listed below. The revocation will be effective immediately upon Twin Cities Community Hospital's receipt of my written notice, except that the revocation will not have any effect on any action taken by Twin Cities Community Hospital in reliance on this Authorization before it received my written notice of revocation.

I may contact Twin Cities Community Hospital's Privacy Office by mail at 1100 Las Tablas Rd., Templeton, CA 93465, OR by telephone at (805) 434-3500 or by e-mail at

TWI-PrivacyOffice@Tenethealth.com.

Additional Copy: I further understand that I have a right to receive a copy of this authorization upon my request. Copy requested and received:

_ Yes No Initial: _____

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Twin Cities Community Hospital to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient/Personal Representative* **Date**

Relationship (if other than patient) _____

Minor's signature is req uired for release of any records for treatment that the minor may authorize under California Law.

Identification of Patient/Personal Representative verified:

Drivers License #_____ ☐ **Other ID #** _____

Signature of person accepting authorization: _____

*"Personal Representative" is any of the following: conservator of the patient's person, an agent appointed by the patient under a power of attorney for health care; executor or administrator of estate; next-of-kin or beneficiary if patient is deceased (obtain copy of death certificate); guardian; person legally obligated to financially support patient.

***Note: If acting as a Conservator, Beneficiary, Power of Attorney, Executor/Administrator of Estate, Beneficiary, or Guardian you must furnish a copy of your appointment papers with this Authorization.**