PATIENT INFORMATION

Patient Name / Aka: _____ Medical Record #: _____
(Please print)

Telephone: _____ Social Security #: _____ Birthdate: _____

INFORMATION TO BE RELEASED FROM:

I hereby authorize the release of information in my medical record from (Provider Name):

University Medical Center

445 S. Cedar Ave. (Address) Fresno (City) CA (State) 93702 (Zip)

Including contents regarding drug or alcohol abuse, psychiatric, *psychotherapy notes and *HIV related (AIDS) diagnosis and/or test results. Exclusions to the above: _____

INFORMATION TO BE RELEASED TO:

Name of Organization / Person _____

Address: _____ City: _____ State: _____ Zip: _____

(*A separate authorization is needed for each HIV disclosure and a specific separate authorization requesting psychotherapy notes is required)

TYPE OF INFORMATION TO BE RELEASED:

Date of Treatment: From _____ To _____

TYPE OF RECORD:

- ☐ All Medical Records (pertinent only) (limited 2 years of information)
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ Consultation Report
- ☐ Other Information (specify) _____
- ☐ Psychotherapy notes only
- ☐ Radiology Report (specify) _____
- ☐ Lab Results
- ☐ Evidentiary Examination
- ☐ ER Report

Purpose or need for this information is: ☐ Medical ☐ Legal ☐ Insurance ☐ Personal ☐ Other

Health Information Management

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

RESTRICTIONS / DURATION / RIGHTS

- I authorize the release of the specified information from my medical records.
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality laws (HIPPA). However, under California law the requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law pursuant to state confidentiality laws.
- This authorization may be revoked at any time. My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- CMC may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- This authorization expires six months after the date of signature, or as specified _____
- A photocopy of this release is as effective as the original.
- I have received a copy of this authorization.
- ☐ If this box is checked, Community Medical Centers will receive compensation for the use or disclosure of my health information.

SIGNATURE: _____ DATE: _____

Patient / Legal Representative / Guardian

If signed by other than patient, indicate relationship: _____

Witness: _____ _____

Print Name Signature

(PHYSICIAN PART ONLY) Records obtained in the course of PSYCHIATRIC TREATMENT. The undersigned, the physician, licensed psychologist, or social worker with a master's degree in social work, hereby (approves) (disapproves) the release of information and records. Please note below any restrictions on the release of records. (NOTE: No approval is required for the release to the patient's attorney.) If denied, please provide reason.

_____

Signature: _____ Date: _____

(Physician / Psychologist / Social Worker)

Interpreter Signature if Applicable:

I have accurately and completely read the foregoing document to _____

Patient's or Legal Representative's Name

In _____, the patient's or legal representative's primary language.

Language

(He/She) understood all of the terms and conditions and acknowledged (his/her) agreement thereto by signing the document in my presence.

FOR OFFICE USE ONLY
ID Checked ☐ Yes ☐ No
Fee Explained ☐ Yes ☐ No
Amount Paid _____ Receipt # _____
☐ Mail ☐ Pick Up
Initials _____

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