

AUTHORIZATION TO USE OR RELEASE PROTECTED HEALTH INFORMATION

I hereby authorize _____

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

Patient Name _____ Date of Birth _____

Address _____ Patient's Phone # (_____)

1. The information is to be used or disclosed to the following **person or entity**:

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 date of service): _____. If this line is left blank, the treatment dates covered by this authorization are from the most recent office visit.

I understand that this authorization extends to all or any part of the records/information designated below. The information to be used or released includes:

- | | | |
|---|--|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Demographic Information |
| <input type="checkbox"/> Pathology | <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Laboratory Data | <input type="checkbox"/> Diagnostic Imaging Reports/Films* | <input type="checkbox"/> Consultation Notes |
| <input type="checkbox"/> Medication Records | <input type="checkbox"/> Assessments | <input type="checkbox"/> Billing/Financial Records |

*List **ALL** dates and types of exams for films to be released

This authorization is limited to only that information that I have requested above to be used or disclosed to the person/entity named herein.

FOR THE RECIPIENT OF THE INFORMATION:

If any of the requested records contain information regarding HIV, alcohol or drug abuse treatment, it is protected by federal confidentiality rules (42 CFR Part 1). 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 STATE LAW REQUIRES A SEPARATE AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORDS, DRUG AND/OR ALCOHOL ABUSE RECORDS AND/OR HIV TEST RESULTS.

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Patient Name _____ DOB _____

1. **Expiration:** I understand that this authorization is in force indefinitely unless I fill in an expiration date or I revoke this authorization in writing.
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 re-disclosed by the receiving party.
3. **Refusal to sign:** I understand that I may refuse to sign this authorization and that Sacramento Clinic for Hematology and Medical Oncology will not condition treatment, payment, or eligibility for benefits on whether I sign this authorization.
4. **Certification:** I certify that I am the patient and the identification that I have provided is true and correct.
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. The revocation must include:
 - Patient's name, address and date of birth
 - The patient's desire to revoke this authorization, and
 - The date of the revocation and the patient's signature
6. **Copy:** I understand that I will receive a copy of this authorization.

I fully understand and accept the terms of this authorization.

X _____
 (Patient Signature) (Date)

Expiration Date (if any) _____

(INTERNAL USE ONLY)

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

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

Please mail form with original signature to:

Sacramento Clinic for Hematology and Medical Oncology
 Attn: Medical Records
 2929 K Street, Suite 200
 Sacramento, California 95816