

Patient Name: _____ **Medical Record#** _____
Address: _____ **Date of Birth:** _____
City/State/Zip _____ **Phone:** _____

Please **OBTAIN** Information **FROM:**

Please **SEND** my medical information **TO:**

Name & Title of Provider/Organization

Name & Title of Provider/Organization

Street Address

Street Address

City/State/Zip

City/State/Zip

Telephone Number

Telephone Number

Fax Number

Fax Number

For the Purpose of: Patient Request Other _____

List specific dates of records to be released: _____

Duration: This authorization shall begin immediately and remain in effect for one (1) year unless otherwise specified as follows: _____ (date or event).

I AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS:

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected. (*Under California law, however, a recipient of medical information, whether disclosed pursuant to an authorization or to the discretionary provisions of California Civil Code #56.10(x), may not further disclose that medical information except in accordance with a new authorization or as specifically required or permitted by law.*)

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment (see page 2 of this form for certain exceptions). I may inspect or obtain a copy of any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing (see page 2 of this form). My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization. I have the right to obtain a copy of this authorization.

Signature: _____
(Patient/Parent/Conservator/Guardian) Date Time

If signed by other than patient, indicate relationship: _____

Authorization to Release Medical Information

San Joaquin Community Hospital

Adventist Health

Retain in Patient Record

(Over)

*****For Office Use Only*****

Date Received: _____ Date Records Sent: _____

Identity of individual and/or legal representative verified

Notes: _____

Medical Record Number

Clerk Initials

*****Revocation of Authorization*****

In accord with provisions of the Notice of Privacy Practices, I hereby revoke the

- Above Authorization
- Authorization releasing information to _____
- Authorization dated _____

Signature: _____
(Patient/Parent/Conservator/Guardian) Date Time

If signed by other than patient, indicate relationship: _____

*****For Office Use Only*****

Date Revocation Received: _____

Identity of individual and/or legal representative verified

Medical Record Number

Clerk Initials

Exceptions: The exceptions noted in the Rights section on page 1 of this form include: authorization for research; authorization for health plan enrollment; and authorization solely for the purpose of creating protected health information for a third party.

Retain in Patient Record