Patient name _____ Date of Birth _____

Address _____ SS# _____

City/State/Zip _____ Phone _____

I hereby authorize _____

(name of facility) to release health information to

Name of physician/ hospital/other _____

Address _____ City _____ State _____ Zip _____

Phone #_____ Fax # _____

the following information: (all dates will be released unless specified).

Date(s) needed _____

❑ Discharge Summary ❑ History & Physical ❑ ER Record ❑ Consultations

❑ Operative Report ❑ Physician Orders ❑ Physician Notes ❑ Diagnostic Tests

❑ Other _____

I authorize the release of the following type of special information (initial all that apply):

_____ HIV test results _____ Mental health treatment _____ Alcohol/drug treatment

Purpose of request: ❑ Personal ❑ Insurance ❑ Disability ❑ Continuing Care

This authorization expires one (1) year from the date signed unless otherwise specified. Insert specified date/event _____

I prefer to receive the information by: ❑ Pick up ❑ Mail ❑ Fax ❑ Other _____

DATE _____ TIME _____ SIGNED _____
(Patient/Parent/Conservator/Guardian)

If signed by other than patient, indicate relationship_____

WITNESS _____

St. Helena Hospital Clear Lake, Clearlake, CA

MEDICAL INFORMATION AUTHORIZATION

* 1 1 2 *
Authorization to Release Medical Info

RB 2559 5/18/15

Patient Identification

Client name _____

Medical Record #_____