MRN #:_____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide *all* information requested may invalidate this Authorization. A picture ID is required to verify the identity of the patient.

Name of patient:_____Date of Birth: _____

USE AND DISCLOSURE OF HEALTH INFORMATION:

I hereby authorize:_____to release to:

_____ _____

(Persons/Organizations authorized to receive the information) *(Relationship to the patient)*

_____ _____ _____

Street Address *City* *State*

The following information:

- ❑ All health information pertaining to my medical history, mental or physical condition and treatment received; **OR**
- ❑ Only the following records or types of health information:

_____Dictated Reports _____ER Report_____x-ray (films/CD)

_____Clinic Records _____Lab _____Dates of Service _____Billing

I specifically authorize release of the following information (check as appropriate):

- ❑ Mental health treatment information_____(initial)
- ❑ HIV test results_____(initial)
- ❑ Alcohol/drug treatment information_____(initial)

PURPOSE:

Purpose of requested use or disclosure: ❑ Patient request

List Limitations, if any:

MRN #:_____

EXPIRATION:

This Authorization shall begin immediately and expires on (date)_____.

MY RIGHTS:

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

Adventist Health Lodi Memorial
Health Information Management
Department 975 S. Fairmont Ave
Lodi, CA 95240

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. I have a right to receive a copy of this authorization. Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained by me or unless such disclosure is specifically required or permitted by law.

SIGNATURE:

Signature:_____Date:____/____/____Time:_____AM/PM

(*Patient/legal representative*) If signed by someone other than the patient, state your legal relationship to the patient:

Relationship:_____Print Name: _____

Email Address:_____Phone: _____

Identification(s) verified by: _____

****

HIM use only

Date:	*Clerk Initials:*	*Records picked up by:*	*CD*	*Fax*	*Paper*	*Mail*	*Page Count*

(*check appropriate box of how the records were released)*

Lodi Health
Adventist Health

975 S. Fairmont Ave.
P.O. BOX 3004
Lodi, CA 95240
(209) 334-3411

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