Client name __________________________________________
Medical Record # ____________________________________

St. Helena Hospital, St. Helena, CA

MEDICAL INFORMATION AUTHORIZATION

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Patient Identification

Client name _________________________________________

Medical Record # ________________________________
I, the undersigned (e.g. physician, licensed psychologist, MSW / MFT), who is in charge of the patient, hereby   
❑ approve   
❑ disapprove   
the release of information and records to the party specified above. If disclosure is disapproved, give 
reasons below. Also note below any restrictions on the release of records. Note: No approval is required for release to the 
patient’s attorney.

________________________________________

DATE ________________  TIME __________  SIGNED ________________________________  TITLE __

Reference:  Welfare and Institutions Code Section 5328.7
Reference:  CFR Title 42, Part 2

Date received ________________  Date records sent: ________________  Medical record # __________

Notes ________________________________________________________________

______________________________________________________________  Clerk’s 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 ________________________________

DATE ________________  TIME __________  SIGNED ________________________________  (Patient/Parent/Conservator/Guardian)

If signed by other than patient, indicate relationship __________________________________________________

WITNESS _______________________________________________________________________

Date revocation received ________________  Medical record # __________________  Clerk's 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.

For Office Use Only