

## Authorization to Release Medical 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.**

Patient Name: \_\_\_\_\_ Medical Record# \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

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

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

Adventist Health Ukiah Valley

\_\_\_\_\_  
Name of Provider / Organization

275 Hospital Drive

\_\_\_\_\_  
Street Address

Ukiah, CA 95482

\_\_\_\_\_  
City/State/Zip

707-463-7353

\_\_\_\_\_  
Telephone Number

707-463-7382

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Name of Provider / Organization

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Fax Number

Paper Copy     Faxed     CD (if available)     E-Mail (encrypted) \_\_\_\_\_

**I authorize the following information to be released:**

a.

Only the following records or types of health information (including any dates): \_\_\_\_\_

\_\_\_\_\_

b. 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)

A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.

**For the Purpose of:**     Patient Request     Other \_\_\_\_\_



Ukiah, CA

Patient Identification

**AUTHORIZATION TO RELEASE  
MEDICAL INFORMATION**

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UK 1946 9/15/17

Limitations, if any: \_\_\_\_\_

Duration: This authorization shall begin immediately and expires on (date): \_\_\_\_\_

- 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: \_\_\_\_\_.
- 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 from me or unless such disclosure is specifically required or permitted by law.

Signature: \_\_\_\_\_  
 (Patient/Parent/Conservator/Guardian)                      Date                      Time

If signed by other than patient, indicate relationship: \_\_\_\_\_

For Behavioral Health Records ONLY - \_\_\_\_\_  
 (Signature of MINOR patient-if applicable)                      Date                      Time

I authorize \_\_\_\_\_ to pick up my medical records.

.....  
**\*\*\*FOR OFFICE USE ONLY\*\*\***

REQUEST COMPLETED - DATE: \_\_\_\_\_ PREPARED BY: \_\_\_\_\_ PAGE COUNT: \_\_\_\_\_  
 IDENTITY OF INDIVIDUAL AND/OR LEGAL REPRESENTATIVE VERIFIED - STAFF INITIALS: \_\_\_\_\_

Notes: \_\_\_\_\_



Ukiah, CA

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Patient Identification