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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION REGARDING MEDICAL, PSYCHIATRIC AND SUBSTANCE ABUSE RECORDS

FOR THE RECIPIENT OF THE INFORMATION: If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I hereby authorize Heritage Oaks Hospital, 4250 Auburn Blvd, Sacramento, CA,95841
Phone: (916) 489-3336 Fax: (916) 830-1278
To receive, use or release health information and records obtained during the course of treatment of:

Name of Patient_____
D.O.B:_____S.S.N#_____Phone #_____
Address:_____

USE AND DISCLOSURE OF HEALTH INFORMATION

The information is to be used or disclosed To/From the following person/organization:
To release to person/entity:_____
Relationship:_____
Address:_____
Phone Number:_____ Fax Number:_____
Dates of Treatment (insert date(s):_____

The following information:

☐ I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for physical and mental illness, alcohol/drug abuse; HIV/AIDS test results or diagnoses. The information to be used and /or released includes:

_____ Discharge Summary
_____ Discharge Instructions
_____ Psychiatric Evaluation
_____Laboratory Data/X-Ray reports
_____History & Physical Exam
_____Face Sheet
_____Billing/Financial Records
_____Medication Records
Other:_____

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

PURPOSE

Purpose of requested use or disclosure: ☐ Patient request ☐ Other:
_____

METHOD of delivery of requested records:
_____ Mail _____ Pick-up _____Electronic delivery, recipient email:

CHARGE

I understand I will be charged **$10.50 PER RECORD AND $.25 PER PAGE FOR** copies sent to myself or family and friends..

EXPIRATION

I understand that unless I revoke the authorization earlier, this authorization will automatically expire 180 days from the date this authorization is signed.

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:

Heritage Oaks Hospital, 4250 Auburn Boulevard, Sacramento, CA 95841

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 re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by Federal confidentiality law (HIPAA).

Place an X here ____if the Requester will receive compensation for the use or disclosure of my information.

SIGNATURE:

Minors: I understand that minors over 12 years old must sign the authorization along with their parent/ guardian.

_____ _____
Patient Signature (Required if Adolescent) (Date)

_____ _____ _____
Parent or Legally Authorized Representative (Date) (Relationship to Patient)

_____ _____ _____
Staff Member/Witness Signature (Print Last Name) (Date)