AUTHORIZATION
FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Providence
St. Mary
Medical Center

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

NOTE: If you are a patient/patient representative requesting medical records for personal use, there may be a fee for production of the medical records.

EXPLANATION

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Name of Patient:			
Date of Birth:	Medical Record #:		
Current Address:	City:	State	Zip:
Home #:	Cell #:		

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby Authorize **St. Mary Medical Center** to release my Medical Records to:

☐ **Myself or** ☐ **Facility/Person below** ☐ **CD** ☐ **Paper** ☐ **Email**

Facility/Person:		Attention:
Address:		Phone:
City:	State: Zip:	FAX:

Delivery Options: ☐ Mail to address above ☐ Fax to number above

☐ Email:_____ @ _____

INFORMATION TO BE RELEASED (Only check one box in this section)

Specify the Date(s) of treatment:_____ _____

☐ Pertinent Information: ***(This is what most patients and physicians need)*** Discharge Summary, Emergency Department Report, History and Physical, Consultations, Operative Reports, Labs, Radiology Reports, EEG, EMG, EKG, Pathology Reports. (a fee may be charged.)

OR ☐ Entire Medical Record (a fee will be charged.)

OR ☐ Only the following records or types of health information: _____

AUTHORIZATION TO RELEASE STATUTORILY PROTECTED INFORMATION

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

☐ Mental health treatment information	Initial and Date:
☐ HIV test results	Initial and Date:
☐ Alcohol/drug treatment information	Initial and Date:

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

PURPOSE

Purpose of requested use or disclosure: ☐ Patient Request ☐ Continuing Care ☐ Legal ☐ Insurance

☐ Other: _____

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EXPIRATION

This Authorization expires (Date):_____

If no Date is given; this authorization will expire 6 months from the signature date.

MY RIGHTS

I may refuse to sign this authorization. If I refuse to sign this authorization, I should know that by law, my health information cannot be released. 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:

St. Mary Medical Center
Health Information Management-Correspondence
18300 Highway 18 • Apple Valley, CA 92307
FAX: 760-946-4219

EMAIL: SYMROI@stjoe.org

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).

SIGNATURE

Patient Signature: _____ Date: _____

Legal Representative Signature: _____ Date: _____
(Patient representative/spouse)

If signed by someone other than the patient, state your legal relationship to the patient and why you have the authority to act for the patient:

Witness Signature: _____ Date: _____