St. Joseph Health
St. Joseph • Redwood Memorial

Authorization to Release Health Information

1. Patient Name: _____Date of Birth:_____
   Phone Number: _____

2. I hereby authorize:
   ☐ St. Joseph Hospital, 2700 Dolbeer Street, Eureka, CA 95501
   ☐ Redwood Memorial Hospital, 3300 Renner Drive, Fortuna, CA 95540
   ☐ Other: _____

3. To disclose (provide) patient's protected health information (PHI) to:

   Name: _____
   (name of authorized person, organization, or clinic)

   Provide the following if you would like records mailed:
   Address: _____
   City/State/Zip Code: _____
   Telephone Number: _____

4. These records are being requested for the following reason:

☐Continuation of Medical Care	☐Legal
☐Disability/Social Security Determination	☐Personal Use
☐Insurance/Payment for Services	☐Other: _____

5. The following information is being requested:

Date(s) of Service (if known): _____

☐Discharge Summary	☐EKG/Cardiology Reports	☐ED Records
☐History and Physical Exams	☐Lab Reports	☐Operative Reports

☐Diagnostic Imaging Reports: X-ray, CT, MRI
☐Diagnostic Imaging on disk (you may be directed to Diagnostic Imaging for images on disk.)
☐ All records – there may be a fee – please ask Health Information Management staff (**St. Joe's:** (707)-445-8121 x7510 **Redwood Memorial:** (707)-725-3361 x7347)
☐Other: _____

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I specifically authorize release of the following information (check all that apply):

☐Drug/Alcohol treatment ☐Mental health treatment ☐HIV test results

I understand that I have the following rights with respect to this Authorization:

The recipient of the protected health information is prohibited from redisclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law.

- I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits.
- I will be provided with a copy of this Authorization.
- I may revoke this authorization at any time, but I must do so in writing and submit it to: Privacy Officer, St. Joseph Hospital, 2700 Dolbeer Street, Eureka, CA 95501. Such revocation will be effective upon receipt, except to the extent that the recipient has taken action in reliance on this Authorization.
- I am entitled to notice if St Joseph or Redwood Memorial Hospital will use or disclose the protected health information for marketing and receive payment for the use or disclosure of my protected health information.

This Authorization will expire on/in:_____(date)

_____ Signature of Patient/Personal Representative

_____ Personal Representative's Authority To Act on Patient's Behalf

_____ Printed Name

_____

_____

_____ Date

_____ Address and Telephone Number of Patient/Personal Representative

Health Information Management (HIM) Department fax #'s:

St. Joe's: (707)- 269-3896 **Redwood Memorial:** (707)-725-7248