

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. **Failure to provide all information requested may invalidate this Authorization.**

USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) _____ Alternate Phone: (____) _____

DOB: _____ SSN: _____

I hereby authorize _____
(name of physician, hospital or health care provider)

to exchange information with:

Name of Requestor: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) _____ Fax: (____) _____

Purpose of requested disclosure: Medical Care Personal Other _____

Date of Service _____

- This Authorization applies to the following information
- History and Physical
 - Discharge Summary
 - Drug Screening
 - Only the following records or types of health information (including any dates): _____
 - Operative Report
 - Mental Health Treatment Info.
 - Worker's Compensation
 - Dialysis Records
 - Labs/X-Rays/HIV Results
 - Alcohol/Drug Treatment Info.
 - Pre-Employment Physical

All health information pertaining to any medical history, mental or physical condition and treatment received, except:

Other _____

Method of Release Fax to: _____

Pick up by Patient Mail to: _____

Pick up by other than patient
Name: _____



EXPIRATION

This Authorization expires one year after signature:

NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization. I have the right to receive a copy of this authorization. I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: Kaweah Delta Health Care District

Health Information Management
400 W. Mineral King
Visalia, CA 93291

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

Neither treatment, payment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might 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.

I may inspect or obtain a copy of the health information that I am being asked to authorize use or disclosure.

I understand that this may include ALL medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition, including *psychological or psychiatric impairment, drug abuse and/or alcoholism, and HIV results.*

If this box is checked, the Requestor will receive compensation for the use or disclosure of my information.

SIGNATURE

Date: _____ Time: _____ am/pm

Signature: _____

(Patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:

Attending must authorize release of Psychiatric and Chemical Dependency records:

Please check one Authorize Release Deny Release

Signature: _____ Date _____
Attending Practitioner Signature

