

Release of Medical Information Form

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

Name of Patient: _____
 Date of Birth: _____ SSN: _____
 Patient Address: _____
 City: _____ State: _____ Zip: _____
 Phone #: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: Shasta Regional Medical Center
 To release to: _____ Covering the period of healthcare from _____ to _____
 Phone #: _____ FAX: _____
 (Persons/Organizations authorized to *receive* the information) (Address – street, city, state, zip code and/or fax number)
 The following information:

- Only the following records or types of health information (including any dates):
- Discharge Summary Consultation(s) All pertinent Lab / X-rays / EKG
 - History and Physical Operative Report Other: _____
 - ER

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

_____ Mental health information _____ STD
 _____ HIV test results _____ Sexual Assault
 _____ Alcohol/drug information _____ Child Abuse/Neglect

PURPOSE

Purpose of requested use or disclosure: patient request; OR other:

EXPIRATION

This authorization expires on: _____

PLEASE CONTINUE ON NEXT PAGE →



MY RIGHTS

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

I may revoke this authorization at anytime, but I must do so in writing and submit it to:

Shasta Regional Medical Center
ATTN: Medical Records
1100 Butte Street
Redding, CA 96001

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 a re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentially 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.

Options of Electronic Format: According to HITECH section 13405(e) (1); 42 U.S.C. 17935 (e) (1), you may have your electronic medical records transmitted to you or another entity in electronic format. Please choose which type of format you would like the information to be delivered in and note the receiving entity may not accept records in electronic format: Burn to a CD Paper

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. Licensed Psychotherapist's approval for geropsychiatric patient:

Witness: _____

