DESERT CARE NETWORK | DESERT REGIONAL MEDICAL CENTER

HEALTH INFORMATION MANAGEMENT
1150 North Indian Canyon Drive, Palm Springs, CA 92262
Office: (760) 323-6289/Fax: (760) 323-6383
Email: DES-DRMC-MedRecords@tenethealth.com

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Patient Name: _____ MRN: _____

Date of Birth: Month _____ Day _____ Year _____ ACCOUNT #_____

I AUTHORIZE:
Desert Regional Medical Center to release health information to:

_____
Name of person or facility to receive your health information

_____
Specify name/title of person to receive your health information, if known

_____
Street Address, City, State, Zip Code

PHONE: _____ **FAX: _____**

INDICATE THE INFORMATION TO BE RELEASED:

- ❒ Emergency Department Report
- ❒ History and Physical
- ❒ Progress Notes
- ❒ Consultations
- ❒ Operative Report
- ❒ Discharge Summary
- ❒ Radiology Reports ❒ CD
- ❒ Laboratory Reports
- ❒ Cardiology Tests
- ❒ Pathology Reports
- ❒ HIV/AIDS Testing, Treatment, Diagnosis
- ❒ Other: _____

SPECIFY THE DATE OR TIME PERIODS FOR THE INFORMATION SELECTED ABOVE:

_____

STATE THE PURPOSE OF THIS RELEASE: ❒ Continuation of Care

- ❒ At the request of the patient/patient representative
- ❒ Other (state reason):

_____

METHOD: ❒Patient Pick Up ❒Mail ❒Fax ❒Email

_____

DESERT REGIONAL MEDICAL CENTER

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

NOTICE: Desert Regional Medical Center and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS:

- I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party.
- I may revoke this authorization at any time provided that I do so in writing and submit it to the Health Information Management Department, Desert Regional Medical Center, 1150 North Indian Canyon Drive, Palm Springs, CA 92262. The revocation will take effect when Desert Regional Medical Center receives the request.
- I am entitled to receive a copy of the Authorization for Release of Information.

EXPIRATION OF AUTHORIZATION:

Unless otherwise revoked, the Authorization expires _____ (insert applicable date or event.) If no date is indicated, this Authorization will expire 12 months after the date of signing this form. Any services provided after the date of signing, will require a new authorization to be completed.

SIGNATURE:

_____ _____

Signature of patient or patient's legal representative Date

_____ _____

Print Name Phone Number

_____

If signed by someone other than the patient, state your relationship to the patient and indicate authority.