DESERT CARE NETWORK | DESERT REGIONAL MEDICAL CENTER
Health Information Management Email- DES-DRMC-MedRecords@tenethealth.com
Phone (760) 323 6289; Fax (760) 323 6383
1150 North Indian Canyon Drive, Palm Springs, California 92262

# AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

**Patient Name: _____MRN: _____**

**Date of Birth: Month _____ Day _____ Year _____**

## I AUTHORIZE:

**DESERT REGIONAL MEDICAL CENTER** to release health information to:
**Name of person or facility which has information to be released**

_____

**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**

**INDICATE THE INFORMATION TO BE RELEASED:**

- ❒ Discharge Summary
- ❒ History & Physical Exam
- ❒ Operative Report
- ❒ Consultation/Evaluation Report
- ❒ Emergency Department Report
- ❒ Laboratory Reports
- ❒ Radiology Reports
- ❒ Pathology Reports
- ❒ EKG Reports
- ❒ Progress Notes
- ❒ Genetic Testing Information
- ❒ HIV/AIDS Testing, Treatment, Diagnosis
- ❒ Mental Health Information
- ❒ Radiology Films/CD
- ❒ Other: _____

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

_____

**STATE THE PURPOSE OF THIS RELEASE:**

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

Initials of Patient/Patient Representative: ____

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**DESERT REGIONAL MEDICAL CENTER**
**AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION**

PATIENT NAME: _____ MRN: _____

**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, including area code

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