



DESERT REGIONAL MEDICAL CENTER

Health Information Management – Phone (760) 323 6289; Fax (760) 323 6201
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:

_____ 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:

- | | |
|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> EKG Reports |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Consultation/Evaluation Report | <input type="checkbox"/> Genetic Testing Information |
| <input type="checkbox"/> Emergency Department Report | <input type="checkbox"/> HIV/AIDS Testing, Treatment, Diagnosis |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Mental Health Information |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> 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: _____

**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.