



HEALTH INFORMATION MANAGEMENT

47-111 Monroe Street, Indio, CA 92201

Telephone: (760) 775-8173 / Fax: (760) 775-8054

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Patient Name: _____ MRN: _____

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

I AUTHORIZE:

JFK Memorial Hospital 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:

- All Medical Records (PHI)
- Discharge Summary
- History and 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
- 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: _____

**JFK MEMORIAL HOSPITAL
AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION**

PATIENT NAME: _____

MRN: _____

NOTICE: JFK Memorial Hospital 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, JFK Memorial Hospital, 47-111 Monroe Street, Indio, CA 92201. The revocation will take effect when JFK Memorial Hospital 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.