Authorization for Release of Protected Health Information

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

Name of Patient: _____ **Date of Birth:** _____
Last, First MI

I hereby authorize: HDMC Holdings L.L.C. to release to:

_____
Name Phone number

_____
Address City State

Date of Visit: _____

This authorization is for full disclosure of the following:

❑ ER records ❑ OP Reports ❑ Cardiology Tests ❑ Lab Reports
❑ H&P ❑ Discharge Summary ❑ Consults ❑ Pathology Reports
❑ Radiology Reports ❑ Other: _____
❑ CD

a. I specifically authorize release of the following information (check as appropriate):

❑ Mental health records ❑ Alcohol/drug treatment records ❑ HIV/STD test results

Purpose:

❑ Personal request ❑ Continuation of Care ❑ Legal Purposes
❑ Insurance purposes ❑ Employer/Military requirement

❑ Other: _____

Method:

❑ Mail ❑ Patient Pick-Up ❑ FAX NO: _____

❑ Other: _____
Name Relationship to Patient

Expiration:

This specific request is valid through _____. If no date specified by patient/representative requesting information, expiration date will automatically be one (1) year from the date of this request. A new Authorization for Release of Protected Health Information form will need to be completed after said expiration date or for other visit dates.

My Rights:

Right to Revoke	I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and submit it to the following address: Hi-Desert Medical Center, 6601 White Feather Rd., Joshua Tree, CA. 92252. My revocation will take effect upon receipt by Hi-Desert Medical Center. I understand that the revocation will not apply to information that has already been released based on this authorization.
Redisclosure	Information disclosed pursuant to this authorization could be re- disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by the federal confidentiality 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.
Other Rights	I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CRF 164.524. I have the right to receive a copy of this authorization. If i have any questions about disclosure of my health information, please call (760) 366-6476 for assistance.

Signature of Patient or Legal Representative: _____ **Date:** _____

If signed by someone other than the patient, indicate relationship: _____

_____

Print Name: _____
(Legal Representative)

❑ *Customer identification/government issued identification verified.* _____
(Staff member's initials and date of release)

HI-DESERT
MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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