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: __________

Other Names Used: ____________________________ Phone #: ____________

Medical Record or Account #: ____________________________
(Hospital use only)

I authorize: ____
(Facility or other provider)

to disclose to: ____
(Persons/organizations authorized to ***receive*** the information)

at the following address: ______________________________________
(Street, city, state and zip code)

The following information contained in the records specified below (check box and initial applicable lines below):

__________ Mental health or developmental disability treatment records (excludes "psychotherapy notes")

__________ Substance abuse treatment records

__________ HIV test results. This authorizes disclosure of laboratory test results only. ***Note: Your records may include information concerning your HIV status even if you do not initial this line.***

❒ **The following records,** specific types of health information, or records for the date(s) of treatment as specified [check applicable box(es)]:

- ❒ Billing Records
- ❒ Consultation Reports
- ❒ Discharge Summary
- ❒ Emergency Room Reports
- ❒ History and Physical
- ❒ Laboratory Tests
- ❒ Procedure Reports
- ❒ Progress Notes
- ❒ X-Ray Reports
- ❒ Date(s): ______________________________________
- ❒ Other: ______________________________________

❒ **All records** regarding my treatment, hospitalization, and outpatient care.
A separate authorization is required for the use or disclosure of psychotherapy notes or research health information.

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PURPOSE: The purpose and limitations (if any) of the requested use or disclosure is:

- ❒ At the request of the patient or personal representative; ***OR***
- ❒ Other: ____

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified: ______________________________
(Insert date)

MY RIGHTS:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: *HIM Department, Oak Valley Hospital District, 350 S. Oak Avenue, Oakdale, CA.* My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

Signature: ____ Date: ____________
(Patient or personal representative)

______________________________________ ______________________________________
(Print name of personal representative) (Relationship to patient)

Patient/Representative Identification Verified. *Initials:* ___________ *Dept.* _____________

For Substance Abuse Treatment Information Only:

The federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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