PO BOX 1009, LONE PINE, CA 93545
PH: (760)876-5501 FX: (760)876-5731

# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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

**PATIENT INFORMATION:**

| PATIENT NAME: | MAILING ADDRESS: |
|---|---|
| DATE OF BIRTH: | CITY, STATE, ZIP: |
| SSN: | PHONE: |

**USE AND DISCLOSURE OF HEALTH INFORMATION**

**I hereby authorize ______________________________________________To obtain information from:**

____________________________________________________________________
Provider Name/Organization/Person or specify SELF if applicable.

____________________________________________________________________
Address

____________________________________________________________________
City, State, and Zip

____________________________________________________________________
Phone

**INFORMATION TO BE DISCLOSED RELATES TO SERVICE DATES: ________________________**

| | |
|---|---|
| ☐ **Entire Medical Record** | ☐ **Test Results (lab, x-ray, etc.)** |
| ☐ **Demographic Information** | ☐ **Discharge Summary** |
| ☐ **History & Physical** | ☐ **Rehab Therapy Notes (PT, OT, Speech)** |
| ☐ **Medical History** | ☐ **Clinic Office Visits Records** |

**** A SEPARATE AUTHORIZATION IS REQUIRED TO AUTHORIZE THE DISCLOSURE OR USE OF MENTAL HEALTH RECORDS****

**PURPOSE OF REQUEST:**

| ☐ **Patient request/ Personal** | ☐ **Healthcare Facility** | ☐ **Other** |
|---|---|---|

**EXPERATION OF AUTHORIZATION**

This authorization expires a year from the date of signature. (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.2
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

  **Southern Inyo Healthcare District**
  **PO BOX 1009**
  **Lone Pine, CA 93545**
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by 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.

**SIGNATURE**

___________________ ________________ _________________________________________

DATE TIME SIGNATURE (PATIENT/REPRESENTATIVE)

IF SIGNED BY OTHER THAN PATIENT, PRINT NAME AND RELATIOINSHIP

_____________________________________________ ____________________________________

NAME RELATIOINSHIP

**INTERNAL USE ONLY**

| *COMPLETED BY:* | *DATE RECORDS MAILED/ PICKED UP:* | *FEE (IF APPLICABLE)* |
|---|---|---|
| | | |