Methodist Hospital of Sacramento
CHW

7500 Hospital Drive
Sacramento, CA 95823

GENERAL

AUTHORIZATION FOR USE AND / OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Note: Do Not Use This Form If Records To Be Release Relate To **HIV Test Results**)

EXPLANATION: *This Authorization is necessary for us to comply with state and federal laws pertaining to the use or disclosure of protected health information ("PHI") about the patient identified below. Please provide all requested information. Failure to provide all requested information may prevent Methodist Hospital of Sacramento from acting on this Authorization.*

Name of Patient ____________________________________ Date of Birth ______________________

Other names [a.k.a.]_________________________________ M.R. or Account # ________________

1. **PERSONS AUTHORIZED TO DISCLOSE PHI**. I authorize the following person(s) or a class of persons to disclose the health information about patient as described in Section 2 below:
METHODIST HOSPITAL – RELEASE OF INFORMATION STAFF

2. **DESCRIPTION OF INFORMATION.** This Authorization permits the use and/or disclosure of the following information about patient: *(Check all applicable boxes)*

☐ **All** my health information pertaining to any medical history, physical condition and treatment received. Except (optional):____

OR,
Only the following records or types of health information and/or only on the specified date(s):
Date(s) of Treatment: ____________________________ Type of Treatment:______________________

☐ Billing records	☐ EKG Results	☐ Medications	☐ Operative Report	☐ X-ray Results
☐ Consultation	☐ History & Physical	☐ Nurse's Notes	☐ Pathology Report	☐ Emergency Room Records
☐ Discharge Summary	☐ Lab Reports	☐ Orders	☐ Progress Notes	

☐ All health information relating to above date(s) or type of treatment
☐ **Others:**____

I understand that the information to be released may also include any medical history, physical or mental condition, services rendered or treatment received.

3. **AUTHORIZED USERS AND RECIPIENTS.** I hereby authorize the following person or class of persons to receive and/or use the health information described in Section 2 above: *[State name and title (if applicable)].*
Name: Appleby & Company, Inc.
Address: 2828 N. Wishon City/State/Zip Fresno, CA 93704

4. **PURPOSE.** I hereby authorize the information checked in Section 2 above to be used and/or disclosed for the following purposes: *(Check all applicable boxes)*

☐ Requested by patient or personal representative
☐ Others:____

5. **RIGHT OF REVOCATION.** I understand that I have the right to revoke this authorization at any time, provided that my revocation is in writing and conforms to requirements described in METHODIST HOSPITAL OF SACRAMENTO Notice of Privacy Practices, which is available online at *www.chw.edu/privacy*, or in person at METHODIST HOSPITAL OF SACRAMENTO.

6. **LIMITS TO REVOCATION.** I understand that my revocation will be effective upon its receipt by the person(s) I authorized in Section 1 but would not be effective to the extent that such persons have acted in accordance with this Authorization and in reliance thereon. With respect to the person(s) I authorized to receive and use health information described in Section 3, if patient (or personal representative) requested this Authorization, any revocation will be effective only when I communicate my revocation directly to them.

7. **REDISCLOSURE.** I understand that if the recipient of my information is Section 3 above is not a healthcare provider, a health plan or health care clearing house or not an entity required to comply with federal or state health privacy regulations, my health information may be further disclosed by such recipient and my information may no longer be protected by state and federal laws.

8. **CALIFORNIA / ARIZONA RESTRICTION.** I understand that a recipient of medical information in California or Arizona may not further disclose medical information about me (patient) unless a new Authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.

9. **RIGHT TO REFUSE TO SIGN.** I understand that I do not have to sign this authorization and that my failure to sign this authorization will not affect my ability to obtain treatment, payment or benefits.

10. **AUTOMATIC ONE-YEAR DURATION.** This authorization will automatically expire after one (1) year from date of execution unless a different end date or event is specified below.
End Date:________________________ or Event Name: ________________________________

11. **COPY RECEIVED.** I acknowledge receipt of a signed copy of this authorization._____ (initial)

______________________________	______________________________
Signature of patient (or personal representative, if applicable)	Date
______________________________	______________________________
Print names of personal representative)if applicable) *(Legal representative, parent, guardian, spouse, financially responsible party*	Relationship to patient (*if signatory is anyone other than patient describe signatory's relationship to patient*
______________________________	______________________________
Address	Witness (optional)
______________________________	______________________________
Phone No.	Type of ID presented. Attach copy (optional)

Patient/Representative Identification Verified: *Initials*__________ *Department* ___________________

<u>ATTENTION RECIPIENT</u>: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS <u>PROHIBITED</u> EXCEPT WHEN IN THE PURPOSE OF THIS DISCLOSURE