

Medical Record#:					
	Date of Birth:				
Address (Street/City/State/Zip):					
	SSN (last 4 digits):				
that apply):	I health information be released from (select all facilities				
☐ Community Regional Medical Center					
☐ Clovis Community Medical Center, 27	·				
•	E. Audubon Drive, Fresno CA 93720, includes				
Advanced Diagnostic Testing Center	r, 7171 N. Cedar Avenue, Fresno CA 93720				
•	North Medical Center Drive West, Clovis CA 93611				
· · · · · · · · · · · · · · · · · · ·	☐ Community Subacute Transitional Care Center, 3003 N. Mariposa, Fresno CA 93703				
•					
2. I hereby authorize the following person/Entity:	sons or entities to receive my health information:				
Telenhone:	Fax:				
<ul> <li>□ Physician Report(s) and Test Result(s)</li> <li>□ Radiology Report(s) Only</li> <li>□ Radiology Image(s) – specify: □ X-Ra</li> <li>□ Laboratory Test(s) Only</li> <li>□ Complete Medical Record (all pages)</li> <li>□ Billing Records</li> <li>□ Other (specify):</li> </ul>	ving date rangetotos)  ay □ Ultrasound □ CT Scan □ MRI □ Mammography  a, excludes Radiology Images				
-	ave permission to release the following sensitive				
information):	following information:				
I specifically authorize the release of the following information:  ☐ Human Immunodeficiency Virus (HIV) test results  (initial)					
☐ Alcohol/Drug Treatment Information	(initial)				
☐ Mental Health Treatment Information	(initial)				
☐ Genetic Test Results	(initial)				
	ze the disclosure or use of psychotherapy notes, as defined in the feder				
Health Information Management  Authorization to Release  Protected Health Information	OFFICE USE ONLY Identification verified by (name): Verified by (method): □ Photo ID □ Matching Signature				



5.	Purpose of Requested Use or Disclosure (tell us how you will use the records):  ☐ Continuation of Medical Care ☐ Personal Use ☐ Insurance ☐ Other (please list):
6.	Requested Format (ONLY check one):  ☐ MyChart/Online Portal ☐ Compact Disc (CD) ☐ Paper Copy ☐ Email (encrypted), provide email address: ☐ Email (unencrypted, note – if you request information to be sent via email unencrypted there is an increased risk information could be read by an unauthorized third party), provide email address:
	Other (must be agreed upon by the patient and provider):
7.	Method of Release for paper copy or CD (ONLY check one):  ☐ Mail ☐ Fax (paper only) ☐ Pick-Up (if applicable)
8.	Expiration: This authorization shall become effective immediately and shall remain in effect for (1) year from the date signed unless a different date is specified here: (initial)
9.	<ul> <li>Your Rights:</li> <li>I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility benefits.</li> <li>I may inspect or obtain a copy of the health information I am being asked to allow the use or disclosure of.</li> <li>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.</li> <li>My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.</li> <li>I revoke this Authorization for Release of Protected Health Information</li> <li>Date of Revocation: Signature:</li> <li>I have a right to receive a copy of this authorization.</li> </ul>
	<ul> <li>If this box is checked, Community Medical Centers will receive compensation for the use or disclosure of my health information.</li> </ul>

Health Information Management
Authorization to Release
Protected Health Information

Date/Time	Patient/Legal Representative* Signature			
If signed by other than pati	ient, print name and indicate	e relationship t	to patient.	
Relationship Print Name				
	ative signing for the patience personal representative		de copies of the legal docume nt of this authority.	
Date/Time	Date/Time Witness Signature # 1/Print Name/Title			
Date/Time	Witness Signature # 2/Print Name/Title			
(Witness Signature #2 requ	uired if patient marks with a	n "X".)		
Interpreter Signature if ap	oplicable:			
I have accurately and comp	oletely read the document to	):		
		in		
	4 41 11		Languago	
 Patient/Legal Re	epresentative Name		Language	
the patient's or legal repres	<i>·</i> sentative's primary language			

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