AUTHORIZATION TO USE AND DISCLOSE
PROCTECED HEALTH INFORMATION

I hereby authorize (Name of Facility/Doctor): ______________________________,

Address: ______________________________

Telephone: ______________________________ Fax: ______________________________

To disclose the following information from the health records of:

Patient name: ______________________________

Date of Birth: ______________________________

Address: ______________________________ Telephone: ______________________________

City, State, Zip: ______________________________

Covering the period of healthcare from: ______________________________ **to** ______________________________

Pertinent Records

Information to be disclosed, please check the appropriate box for the specific information requested:

- ☐ Complete Health Records
- ☐ Laboratory Tests
- ☐ Consultation Reports
- ☐ X-ray / Imaging Reports or CD
- ☐ Soap Notes / Progress Notes
- ☐ Other: ______________________________

Highly Confidential PHI (Will not be release without specific consent)

By initialing the line(s) below, I specifically authorize the use and / or disclosure of the type of highly confidential information indicated:

Sexual Assault: ______________

Child Abuse or Neglect: ______________

Domestic Abuse: ______________

Substance Abuse: ______________

(Prevention or Treatment)

HIV / AIDS: ______________

(Testing, Diagnosis, or Treatment (regardless of results))

Developmental Disability: ______________

Mental Illness: ______________

Psychotherapy Notes: ______________

Communicable Disease: ______________

1355 East Street, Suite 200 Redding, CA 96001 T: (530) 605-4260 F: (530)605-4265

AUTHORIZATION TO USE AND DISCLOSE PROCTECED HEALTH INFORMATION

This information is to be disclosed to:

Name: ____

Address: ____

Telephone: ______________________________ **Fax:** ____

For the purpose of: ____

I understand that the information disclosed above may be re-disclosed to additional parties by the recipient and no longer protected for reasons beyond the control of Shasta Regional Medical Group.

I understand I have the right to:

1. Revoke this authorization by sending written notice to Shasta Regional Medical Group. The revocation will be effective immediately upon Shasta Regional Medical Group's receipt of my written notice, except that the revocation will not have any effect on any action taken by Shasta Regional Medical Group in reliance before it received my written notice of revocation.
2. Inspect a copy of the Patient Health Information being used or disclosed under federal law.
3. Refuse the right to sign this authorization.
4. Receive a copy of this authorization.

Current charge for CD's is $10.00, Records are $.25 per page.
Records will be copied within 7 days according to California Law (Health and Safety code Sections 123100-123149)

Effective dates of authorization: _______/______/______ through ______/______/______

If no date(s) are specified it will expire 6 months from the date the Authorization is signed.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Shasta Regional Medical Group to use or disclose my health information in the manner described above.

____ ___________________________

Patient or Personal Representative Signature Date

____

Relationship to Patient

1355 East Street, Suite 200 Redding, CA 96001 T: (530) 605-4260 F: (530)605-4265