Completion of this document authorizes the disclosure and / or use of health information, about you. Failure to provide *all* information requested may invalidate the Authorization. *Return the completed form and a color copy of your ID to the Health Information Management (HIM) Department. 2000 Mowry Ave., Fremont CA 94538 OR by email to ROI@WHHS.COM. Phone 510-818-6629*

Patient name: _____

Date of Birth: _____ Date(s) of Treatment: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

☐ I hereby authorize Washington Hospital Healthcare System to release to:

☐ I hereby authorize _____ to release to:

Name of Agency / Facility / Person:_____

Address: _____

City, State, Zip Code:_____

Telephone Number: (_____) _____ FAX: (_____) _____

Email:_____

the following information:

a. ☐ Disch Summary ☐ Operative / Proc Report ☐ Lab Results

☐ Pertinent Info Packet ☐ Complete Medical Record ☐ Radiology Report

☐ Other _____

b. I specifically authorize release of the following information (Initial if applicable):

_____ Mental Health Treatment Information

_____ HIV Test Results

_____ Alcohol / Drug Treatment Information

Preferences

☐ Paper
☐ CD
☐ Electronic

Delivery Options

☐ Mail
☐ Pick Up
☐ Electronic

PURPOSE

Purpose of requested use or disclosure:

☐ Attorney / Legal ☐ Continuing Medical Care ☐ Insurance

☐ Patient Access ☐ Other _____

PATIENT LABEL

Washington Hospital Healthcare System
2000 Mowry Avenue, Fremont, California 94538-1716 • (510) 797-1111

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

EXPIRATION

This Authorization expires 30 days from the date this authorization is signed.

MY RIGHTS

- I understand I may be charged a service fee.
- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and mailed to this address:

  Washington Hospital, Attn: HIM Department, 2000 Mowry Avenue, Fremont, CA 94538
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have the right to receive a copy of this authorization.
- I may inspect and obtain copy of my health information for which I am authorizing the use or disclosure for as long as the information is maintained by the affiliate(s) listed above.
- I understand that California law prohibits the recipients of my health information from making further disclosure of my health information unless the recipient obtains another authorization from me or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.
- I hereby certify **under penalty of perjury** that all information on this application is true and correct to the best of my knowledge and belief. Initials: _____

SIGNATURE

Date: _____ Time: _____am / pm

Signature: _____

Printed name: _____

If signed by someone other than the patient, state your legal relationship to the patient:

_____

Witness: _____

PATIENT LABEL

Washington Hospital Healthcare System
2000 Mowry Avenue, Fremont, California 94538-1716 • (510) 797-1111

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION