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. 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 (check 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 may inspect or obtain a copy of my requested health information and understand I will be charged a fee of *up to .25¢ per page.*

I may revoke this Authorization at any time, but I must do so in writing and submit it to Washington Hospital Healthcare System — HIM Department 2000 Mowry Avenue, Fremont, CA 94538.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of the Authorization.

The recipient of the protected health information is prohibited from redisclosing the information unless the recipient obtains another authorization or unless the disclosure is specifically required or permitted by law.

SIGNATURE

Date: _____ Time: _____am / pm

Signature: _____

(Patient)

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

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