Eastern Plumas Health Care
"People Helping People"

# AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION



Please mail or fax a copy of this Authorization form to:
Eastern Plumas Health Care Attention Medical Records
500 1st Ave
Portola, CA 96122
Phone: 530-832-6542
Fax: 530-832-1438

**There may be fees incurred for this service.**

## Patient Information

Patient Name: _____ DOB: _____ (Office Use)MRN: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email: _____

## Type of Access Requested

☐ Paper Copy ☐ CD ☐ Inspection Only
☐ Email *(Note: If you would like us to send information over email, this increases the risk that information could be read by an unauthorized third party.)*

## Delivery Method

☐ Mail ☐ Email ☐ Fax ☐ Pick-Up

## Purpose of Requested Use or Disclosure

☐ Continuity of Care – Appointment Date with Physician: _____
☐ Patient ☐ Insurance ☐ Other: _____

## Authorization – I hereby authorize:

_____
(Name of hospital, physician, healthcare provider)

_____
Address City State Zip

_____
Phone Fax

**To release my health information to:** ☐ Check this box if same as patient listed above. ***OR***

_____
(Name of hospital, physician, healthcare provider, other)

_____
Address City State Zip

_____
Phone Fax

## Information Disclosure

**Information to be disclosed for the following date range** _____ **to** _____:
☐ Hospital Records (Inpatient and Outpatient)
☐ Clinic (Specify Provider Name): _____
☐ Radiology Report(s) Only
☐ Radiology Images (Specify): ☐ X-ray ☐ Ultrasound ☐ CT scan ☐ MRI ☐ Mammography
☐ Laboratory Test(s) Only
☐ Other: _____

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Please mail or fax a copy of this Authorization form to:
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500 1st Ave
Portola, CA 96122
Phone: 530-832-6540
Fax: 530-832-1438

## Special Authorization *(Tell us if we have permission to release the following sensitive information)*

**I specifically authorize release of the following information:**

☐ STI & HIV results _____ (initial)

☐ Mental Health & Drug and Alcohol Dependency _____ (initial)

## Expiration

This authorization shall become effective immediately and shall remain in effect for one (1) year from the date signed unless a different date is specified here: _____

## Restrictions

California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

## Your Rights

- 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 delivered to this address:
  EASTERN PLUMAS HEALTH CARE ATTENTION MEDICAL RECORDS
  500 1ST AVE
  PORTOLA, CA 96122
- My revocation will be effective upon receipt, but will have no impact on uses or disclosure made while my authorization was valid.
- I have a right to receipt a copy of this authorization (required if authorization is requested for the provider's use or disclosure of health information).
- I may inspect and obtain a copy of the health information of which I am authorizing the use or disclosure of my health information.

## Signature *(As required by law)*

SIGNATURE: _____ Date: _____ Time: _____

(Patient/Legal Representative)

If signed by other than the patient, print name and relationship:

Name: _____ Relationship: _____

**Office Use Only** Identification verified by (name): _____

Verified by (method): ☐ Photo ID ☐ Matching Signature ☐ Other: _____