MARSHALL MEDICAL CENTER AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

To release my health information to:	Patient Name:	Date of Birth:		
Citreet Address, City, State, Zip Code Citreet Address from date	I hereby authorize:	To release my health inform	nation to:	
Citreet Address, City, State, Zip Code Citreet Address from date				
Phone/Fax number and/or email) (Phone/Fax number and/or email) Type of health information to be released Type of health information will not be delivered via email) Type of Records from date to	(Name of person/facility to release health information)	(Name of person/facility to receive health info	ormation)	
Phone/Fax number and/or email) (Phone/Fax number and/or email) Type of health information to be released Type of health information will not be delivered via email) Type of Records from date to				
Type of health information to be released Hospital Records from date	(Street Address, City, State, Zip Code)	(Street Address, City, State, Zip Code)		
Type of health information to be released Hospital Records from date	/Phone/Fax number and/or emails	(Phone/Fax number and/or email)		
Hospital Records from date				
□ Clinic Records from date to □ Billing Records from date to □ Radiology Images (\$5 CD only) from date to □ Records from specific provider or department: □ from date to □ Drug/Alcohol abuse treatment records □ (initial) □ Trug/Alcohol abuse treatment records □ (initial) □ Other □ from date to □ Drug/Alcohol abuse treatment records □ (initial) □ Genetic testing information □ (initial) □ Type of Release: □ Paper (first 20 pages are no charge, \$0.25 per additional page) □ Electronic F-mail □ On-site inspection □ Electronic F-mail □ On-site inspection □ Electronic F-lash Drive (\$5 fee) □ Patient/Patient Representative □ Other: □ Vour Rights: (1) I may refuse to sign this authorization. (2) My refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits. (3) I may inspect or obtain a copy of the health information that I am being asked to allow the disclosure of. (4) I may revoke this authorization at any time, but I must do so in writing, signed by me or my representative, and submit it to: Marshall Medical Center, Health Information Management, at the above address. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization expires: □ (insert date). If no date is indicated, the authorization will expire 12 months after the date of my signing this form. Notice: Fees may apply for copies of your records. Unless required by law, California law prohibits the recipient from further disclosing your health information without another authorization from you. If you have authorized the disclosure to someone not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. Signature: Print Name Signature of Patient or Representative Relationship to Patient	• • • • • • • • • • • • • • • • • • • •	not be released unless you spe	ecifically authorize:	
Billing Records from date to Radiology Images (\$5 CD only) from date to Records from specific provider or department: Records from specific provider or department: Drug/Alcohol abuse treatment records (initial) Drug/Alcohol abuse treatment pages to the treatment page Drug/Alcohol abuse treatment pages are no charge, \$0.25 per additional page) Electronic E-mail On-site inspection Electronic Flash Drive (\$5 fee) Fax Release to MyChart Electronic CD (\$5 fee) Release to MyChart Drug/Alcohol abuse treatment Drug/Alcoholol abuse treatment Drug/Alcoholol abuse treatment Drug/Alcoholol abuse treatment Drug/Alcoholol abuse treatment Drug/Alcoholology Drug/Alcoholo		(this type of sensitive information will not	be delivered via email)	
Radiology Images (\$5 CD only) from dateto				
HIVAIDS pos/neg test results			or Disclosure of Psychotherapy	
Genetic testing information	☐ Records from specific provider or department:	☐ Drug/Alcohol abuse treatment	records (initial)	
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Verbal communication from date	Other	_ ☐ Genetic testing information	(initial)	
Delivery Method: □ Mail □ Fax □ □ Pick-Up □ E-mail □ □ On-site inspection □ Pick-Up □ E-mail □ □ Fax □ □ Electronic E-mail □ □ On-site inspection □ Pick-Up □ E-mail □ □ Fax □ □ Electronic Flash Drive (\$5 fee) □ Fax □ Pick-Up □ E-mail □ □ Patient/Patient Representative □ Other: □ Your Rights: (1) I may refuse to sign this authorization. (2) My refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits. (3) I may inspect or obtain a copy of the health information that I am being asked to allow the disclosure of. (4) I may revoke this authorization at any time, but I must do so in writing, signed by me or my representative, and submit it to: Marshall Medical Center, Health Information Management, at the above address. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. (5) I have a right to receive a copy of this authorization. Expiration of Authorization: This authorization expires: (insert date). If no date is indicated, the authorization will expire 12 months after the date of my signing this form. Notice: Fees may apply for copies of your records. Unless required by law, California law prohibits the recipient from further disclosing your health information without another authorization from you. If you have authorized the disclosure to someone not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. Signature: Print Name Paper Representative Patient or Representative Relationship to Patient Rela		Type of Release:		
Belevery Method: Electronic E-mail On-site inspection Electronic Flash Drive (\$5 fee) Fax Release to MyChart Electronic CD (\$5 fee) Fax Release to MyChart Electronic CD (\$5 fee) Release to MyChart Electronic CD (\$5 fee) Twenty increase the risk of your information being released to unauthorized third parties All electronic is encrypted Other: Your Rights: (1) I may refuse to sign this authorization. (2) My refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits. (3) I may inspect or obtain a copy of the health information that I am being asked to allow the disclosure of. (4) I may revoke this authorization at any time, but I must do so in writing, signed by me or my representative, and submit it to: Marshall Medical Center, Health Information Management, at the above address. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. (5) I have a right to receive a copy of this authorization. Expiration of Authorization: This authorization expires: (insert date). If no date is indicated, the authorization will expire 12 months after the date of my signing this form. Notice: Fees may apply for copies of your records. Unless required by law, California law prohibits the recipient from further disclosing your health information without another authorization from you. If you have authorized the disclosure to someone not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. Signature: Signature of Patient or Representative Relationship to Patient			.25 per additional page)	
Pick-Up E-mail E-mail Release to MyChart Release to MyChart Release to MyChart Release to MyChart Patient Representative Other: Your Rights: (1) I may refuse to sign this authorization. (2) My refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits. (3) I may inspect or obtain a copy of the health information that I am being asked to allow the disclosure of. (4) I may revoke this authorization at any time, but I must do so in writing, signed by me or my representative, and submit it to: Marshall Medical Center, Health Information Management, at the above address. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. (5) I have a right to receive a copy of this authorization. Expiration of Authorization: This authorization expires: (insert date). If no date is indicated, the authorization will expire 12 months after the date of my signing this form. Notice: Fees may apply for copies of your records. Unless required by law, California law prohibits the recipient from further disclosing your health information without another authorization from you. If you have authorized the disclosure to someone not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. Signature: Print Name Signature of Patient or Representative Relationship to Patient Relationsh	Delivery Method:			
The purpose of this release is for: Patient/Patient Representative Other: Your Rights: (1) I may refuse to sign this authorization. (2) My refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits. (3) I may inspect or obtain a copy of the health information that I am being asked to allow the disclosure of. (4) I may revoke this authorization at any time, but I must do so in writing, signed by me or my representative, and submit it to: Marshall Medical Center, Health Information Management, at the above address. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. (5) I have a right to receive a copy of this authorization. Expiration of Authorization: This authorization expires: (insert date). If no date is indicated, the authorization will expire 12 months after the date of my signing this form. Notice: Fees may apply for copies of your records. Unless required by law, California law prohibits the recipient from further disclosing your health information without another authorization from you. If you have authorized the disclosure to someone not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. Signature: Signature of Patient or Representative Relationship to Patient		☐ Electronic Flash Drive (\$5 fee)	☐ Fax	
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Date Interpreter Signature, if applicable		nature of Patient or Representative	Relationship to Patient	
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Original: Chart Copy: Patient Page 1 of 1 (6/19) AuthForDisclosureMedInformation