MARSHALL MEDICAL CENTER

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

I hereby authorize:	**To release my health information to:**
_____ *(Person/facility to release health information)*	_____ *(Person/facility to receive health information)*
_____ *(Street Address, City, State, Zip Code)*	_____ *(Street Address, City, State, Zip Code)*
_____ *(Phone/Fax number and/or email)*	_____ *(Phone/Fax number and/or email)*

Type of health information to be released:

Please note: *The previous two (2) years of health records from date of signature will be released unless otherwise stated below:*

❑ **Other records** _____
from date _____ *to* _____

❑ **Radiology images CD** *($5 fee)*
from date _____ *to* _____

❑ **Verbal communication**
from date _____ *to* _____

Delivery method:

❑ **Mail** ❑ **Pick-Up**

❑ **Fax** _____

❑ **Email*** _____

**Email delivery may increase the risk of your information being released to unauthorized third parties*

The information below is protected by law and will not be released unless you specifically authorize:
(this type of sensitive information will not be delivered via email)

❑ **Mental health** *(other than psychotherapy notes*)*
_____ *(initial)*

**For psychotherapy notes complete the Authorization for Disclosure of Psychotherapy notes to Third Parties (form# 0581528)*

❑ **Drug/alcohol abuse treatment records** _____ *(initial)*

❑ **HIV/AIDS pos/neg test results**
_____ *(initial)*

❑ **Genetic testing information**
_____ *(initial)*

Type of release:	
❑ Paper *(first 20 pages are no charge, $0.25 per additional page)* ❑ On-site inspection ❑ Fax ❑ Electronic email*	❑ Electronic flash drive* *($5 fee)* ❑ Electronic CD* *($5 fee)* ❑ Release to MyChart **All electronic is encrypted*
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 1100 Marshall Way, Placerville, CA 95667. 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*
_____	_____	
Date	*Interpreter Signature, if applicable*	