SHASTA REGIONAL MEDICAL CENTER

# Release of Medical Information Form

Completion of this document authorizes the disclosure and/or use of health information about you.
Please be sure to provide *all* information requested. Failure to do so may invalidate this authorization.

Name of Patient: ____________________
Date of Birth: ____________________ SSN: ____________________
Patient Address: ____________________
City: ____________________ State: ________ Zip: ____________
Phone #: ____________________

## USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: ____________________
To release to: ____________________ Covering the period of healthcare from ________ to _____
Phone #: ____________________ FAX: ____________________
(Persons/Organizations authorized to *receive* the information) (Address – street, city, state, zip code and/or fax number)
The following information:

☐ Only the following records or types of health information (including any dates):

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ ER
- ☐ Consultation(s)
- ☐ Operative Report
- ☐ All pertinent Lab / X-rays / EKG
- ☐ Other: ____________________

I specifically authorize release of the following information (initial as appropriate):

________ Mental health information
________ HIV test results
________ Alcohol/drug information
________ STD
________ Sexual Assault
________ Child Abuse/Neglect

## PURPOSE

Purpose of requested use or disclosure: ☐ patient request; OR ☐ other:
____________________
____________________

## EXPIRATION

This authorization expires on: ____________________

**PLEASE CONTINUE ON NEXT PAGE →**

## MY RIGHTS

I may inspect or obtain a copy of the health information that I am being asked to allow the use of disclosure of.

I may revoke this authorization at anytime, but I must do so in writing and submit it to:

Shasta Regional Medical Center
ATTN: Medical Records
1100 Butte Street
Redding, CA 96001

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 this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such a re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentially law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

Options of Electronic Format: According to HITECH section 13405(e) (1); 42 U.S.C. 17935 (e) (1), you may have your electronic medical records transmitted to you or another entity in electronic format. Please choose which type of format you would like the information to be delivered in and note the receiving entity may not accept records in electronic format: ☐ Burn to a CD ☐ Paper

## SIGNATURE

Date: ______________________________ Time: ________________________am/pm

Signature: ____________________________________________________________
*(patient / representative / spouse / financially responsible party)*

If signed by someone other than the patient, state your legal relationship to the patient. Licensed Psychotherapist’s approval for geropsychiatric patient:

______________________________________________________________________

Witness: _____________________________________________________________