Health Information Management
2170 South Ave.-South Lake Tahoe, CA 96150
Phone (530) 543-5900 – Fax (530) 544-1458

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure, receipt, and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.

FAILURE TO PROVIDE *ALL* INFORMATION REQUESTED MAY INVALIDATE THIS AUTHORIZATION.

Patient Name: ______________________ Phone # ______________________
(print name)
Health Record Number: _________________ Date of Birth: _______________

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize **Barton Health** at: 2170 South Ave.**, South Lake Tahoe, CA 96150,** to use or disclose the patient's health information as described below to the person(s) listed below: **Health information is to be disclosed to and used by:**
______________________________at:______________________________________
(Address must be completed)

For the purpose(s) of requested use or disclosure:

- ❑ At the request of the individual
- ❑ Insurance
- ❑ Attorney
- ❑ Continued Care (please specify____
- ❑ Other (specify each purpose) ____

Description or nature of information to be used and/or disclosed:

- ❑ Records for the following dates: _______________________________________
- ❑ Physician Dictation
- ❑ Laboratory Reports
- ❑ Radiology/X-Ray Reports
- ❑ Emergency Department Record
- ❑ Records for the following treatment:___________________________________
- ❑ Billing statements for the following dates: ______________________________
- ❑ Other: ____
- ❑ All Records ____

Taking your health to **new heights**

Date: 2/18/03
Revision Date: 5/19/10; 1/12/11

I authorize the information listed below to be used, disclosed, and/or received:
❑ Mental health/Development disability ❑ HIV / AIDS
❑ Drug and/or alcohol abuse diagnosis, prognosis, or treatment
Information to be released and how it will be used (describe how much and what kind): ____
The above information will not be released or disclosed unless specifically authorized.

EXPIRATION

This Authorization expires: DATE____________________________________

NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization. No treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this Authorization.
I may revoke this Authorization at any time. My revocation must be in writing, signed, and delivered to the following address: Privacy Officer, Barton Health, 2170 South Ave., South Lake Tahoe, CA 96150. My revocation will be effective upon receipt, but will not be effective to the extent that Barton Health or others have acted in reliance upon this Authorization. I may request a copy of this Authorization if needed.
Information disclosed under this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state confidentiality law. California law, however, prohibits the person receiving the patient's health information from further disclosing of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE

Date: ___________________________ Time: __________________ am/pm

Signature: ____
(patient/personal representative)
If signed by someone other than the patient, state your legal relationship to the patient and your grounds for authority: _________________________________

Witness:____

For Barton Use Only

Documentation provided:
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