



Barton Community Health Center – Pediatrics  
2201 South Ave.-South Lake Tahoe, CA 96150  
Phone (530) 543-5550 – Fax (530) 542-8734

## AUTHORIZATION FOR USE, DISCLOSURE, OR RECEIPT OF HEALTH INFORMATION

Completion of this document authorizes the Use and Disclosure or Receipt of health information about you, consistent with California and Federal Privacy laws.

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

Patient Name: \_\_\_\_\_ Phone # \_\_\_\_\_  
(print name)

Medical Record Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize, Barton Health, **to Release to:**

\_\_\_\_\_  
(Persons/Organizations authorized to receive the information)

**OR** authorize Barton Health, **to Request from:**

\_\_\_\_\_  
(Persons/Organizations requesting records from)

At: \_\_\_\_\_  
(Address-street, city, state, zip code) (phone or fax if applicable)

***The following information to be released or requested:***

All health information pertaining to my medical history, mental or physical condition and treatment received; **OR**

**Only:**

Records for the following dates: \_\_\_\_\_

Physician Dictation

Laboratory Reports

Radiology/X-Ray Reports

Emergency Department Records

Records for the following specific treatment: \_\_\_\_\_

**OR**

Billing statements for the following dates: \_\_\_\_\_

Other: \_\_\_\_\_

**I specifically authorize Release of the following information**

**(check as appropriate):**

- Mental health treatment/Development disability \_\_\_\_\_(initial)
- HIV test results / AIDS treatment \_\_\_\_\_(initial)
- Genetic Information \_\_\_\_\_ (initial)
- Alcohol/Drug treatment \_\_\_\_\_ (initial)

**The above information will not be released or disclosed unless specifically authorized.**

**NOTICE OF RIGHTS AND OTHER INFORMATION**

“I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information and may revoke this authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed. The written revocation must be signed and forwarded to: ***Privacy Officer, Barton Health, 2170 South Ave., South Lake Tahoe, CA 96150.***
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily, and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom this information is released or disclosed pursuant to this authorization, may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.”

**SIGNATURE**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

Signature: \_\_\_\_\_

*(Patient or Legal representative)*

If signed by a person other than the patient, indicate your legal relationship:

\_\_\_\_\_

Print Name: \_\_\_\_\_

*(Legal representative)*

**AUTHORIZATION EXPIRATION**

This Authorization expires: \_\_\_\_\_ (date)

*(one year from date of signature)*

Witness Signature: \_\_\_\_\_ (date)