AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
Health Information Management

2170 South Ave., South Lake Tahoe, CA 96150
Phone (530) 543-5900/Fax(530) 544-1458
medicalrecords@bartonhealth.org

Patient Information	NAME: ______________________________ DATE OF BIRTH: ________ ADDRESS: ____ CITY: ________________________________STATE: ______ ZIP: _______ PHONE: ___________ FAX: ___________ EMAIL: __________________ MEDICAL RECORD #: ________________________
Clinic/Hospital/ Health Provider (Who is providing the protected health information (PHI))?	NAME: ____ ADDRESS: ____ CITY: ______________________________ STATE: _______ZIP: _______ PHONE: ___________ FAX: ___________EMAIL: ___________________
Receiving Person/ Organization (Who is receiving the PHI?)	NAME: ____ ADDRESS: ____ CITY: ______________________________ STATE: _______ZIP: _______ PHONE: ___________ FAX: ___________EMAIL: ___________________
Dates of Service For Request	From Date: ______________________ To Date: _______________________ (month/day/year) (month/day/year)
Information (PHI) To Be Released (Check box for information you are authorizing for release)	**Routine Record Sets:** ☐ Hospital-PERT PACK(includes history & physical, discharge report, consults, operative report, emergency report, lab/radiology test results) ☐ Labs (Only) ☐ Radiology Reports/Images-CD (Only) ☐ Physical/Occupational Therapy ☐ Other ___________ ☐ Clinic (office visit, lab, radiology, immunizations) **Billing Statements:** ☐ Hospital ☐ Clinic
Special Authorization Required For Release Of:	☐ Alcohol/substance use disorder treatment information ☐ Genetic Testing information ☐ HIV test results ☐ Mental Health treatment information* *Separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing HIPAA.
Release Delivery Method	☐ Mail ☐ Fax ☐ Pick-Up ☐ CD ☐ My Chart Portal ☐ Secure Email -Please initial here ______, to indicate you understand the security risk involved that once the information leaves Barton's secure mode of transmission, the communication may be read/intercepted by a third party.
Purpose For This Release (How is the PHI to be used?)	☐ Patient/Pt. Representative ☐ Treatment/Continued Care ☐ Legal ☐ Other/Description: ____ (This information will not be used for any purpose other than its intended use.)

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Patient Rights By signing this authorization, I understand:	• I authorize the use or disclosure of my Protected Health Information as described for the purpose(s) listed. I have a right to receive a copy of this authorization. • I may refuse to sign this authorization, and refusal to sign will not affect my treatment, payment, or my eligibility for benefits. • I have the right to revoke this authorization, in writing. Revocation will not affect uses/disclosures that have already occurred. • I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. • Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosures is obtained from me or unless such disclosure is specifically required or permitted by law.
Patient Signature	Signature: ______________________________ Date: ______ Time: _______ Your signature authorizes the release of information to the same person(s) as designated, for treatment provided after the date of this signature, as long as such treatment occurs before the expiration date below.
Personal Representative Information	Name: ____ Representative Signature: _________________ Date: ______Time: _______ Relationship To Patient: _________________ Phone#: _________________ Address: _____________________City/State: _________________________
What Legal Authority Do You Have to Request PHI	☐ Parent of Minor ☐ Executor of Will ☐ Guardian ☐ Administrator of Estate ☐ Conservator ☐ Other: _________________________ ☐ Power of Attorney
<u>**OFFICE USE**</u> **Auth Expiration**	Unless otherwise revoked, this authorization expires 12 months from the date of signing of this form. Expires: _____________________________
Release of Information Staff - ID Verification	IDENTIFICATION TYPE: ☐ Driver's License/State ID ☐ Employee ID ☐ Social Security Card ☐ Other ____________________ ☐ ID ON FILE REVIEWED ID Verified By: ______________________________________(BMH staff name)

Please Note: State Regulations Allow 15 Days From Receipt Date of Request to Provide Copies of Records.

#8700-E0004 Date: 2/18/03; Revisions: 5/19/10; 1/12/11; 12/16/13; 5/7/14; 3/20/19