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

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: ____

Taking your health to new heights

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

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)