

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:	MR#:
Date of Birth:	Last 4 digits SSN:

I authorize the following organization to release information as stated below from the patient health record:

Information to be Released FROM:	Information to be Released TO:
<input type="checkbox"/> <b>Stanislaus Surgical Hospital</b> 1421 Oakdale Rd, Modesto, CA	<input type="checkbox"/> Outside Hospital <input type="checkbox"/> Self <input type="checkbox"/> Physician <input type="checkbox"/> Other
<input type="checkbox"/> <b>Precision Imaging</b> 1239 McHenry Ave, Modesto, CA	Name: <hr/> Street Address: <hr/> City:                              State:                              Zip: <hr/> Phone: (    )    -              Fax: (    )    -

Information to be Released:
<i>Please indicate dates of service for records requested:</i>
<b>Beginning:</b> _____ <b>Through:</b> _____

<input type="checkbox"/> Anesthesia Report	<input type="checkbox"/> EKG	<input type="checkbox"/> Operative Report
<input type="checkbox"/> Billing Statement	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Consultation/Evaluation	<input type="checkbox"/> HIV/AIDS test or treatment	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Laboratory report	<input type="checkbox"/> Radiology & Diagnostic - <i>Images (x-ray films, etc)</i>
<input type="checkbox"/> Endoscopic Images	<input type="checkbox"/> All Records	<input type="checkbox"/> Radiology & Diagnostic Reports (MD dictation)

Purpose of Release
<input type="checkbox"/> Continuity of Care <input type="checkbox"/> Personal Health Record <input type="checkbox"/> Physician Request at Time of Visit
<input type="checkbox"/> Other (please explain): _____

**Release of Information (continued)**

**Authorization for General Release of Information**

I understand that:

- Stanislaus Surgical Hospital is among many other hospital and physician providers that are required by law to keep your health information confidential. If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, it may no longer be protected by State or Federal confidentiality laws.
- Authorizing the disclosure of my healthcare information is voluntary. Treatment, payment or eligibility of benefits are not conditioned on signing this authorization except if the authorization is for: (1) conducting research-related treatment; (2) to obtain information in connection with eligibility or enrollment in a health plan; (3) to determine an entity's obligation to pay a claim; or (4) to provide health information to a third party.
- I may revoke this authorization at any time, provided I do so in writing **and** submit it to the Health Information Management department at Stanislaus Surgical Hospital. The revocation will take effect when SSH receives it, except for information that has already been released prior to receiving the written revocation. This information cannot be recalled.
- I am entitled to receive a copy of this Authorization.

**↻ EXPIRATION OF AUTHORIZATION ↻**

Unless otherwise revoked, this Authorization expires on \_\_\_/\_\_\_/\_\_\_ (date). If no date is indicated, this Authorization will expire TWELVE months AFTER the date of signing this form.

**Signature of Patient/Legal Representative**

\_\_\_\_\_:\_\_\_\_am/pm      \_\_\_/\_\_\_/201\_\_\_  
 Signature of Patient/Legal Representative      Time      Date

\_\_\_\_\_  
 Print name      Relationship to patient

(\_\_\_\_)\_\_\_\_-\_\_\_\_  
 Phone # with area code      Witness or Interpreter (if patient unable to sign)