STANISLAUS SURGICAL HOSPITAL
1421 Oakdale Road Modesto, CA 95355 209-572-2700 Fax:209-523-5427
Precision Imaging, 1239 McHenry Ave., Modesto, CA 95350 209-491-5200 Fax: 209-526-0935

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:**
	☐ Outside Hospital ☐ Physician ☐ Other
☐ **Stanislaus Surgical Hospital** 1421 Oakdale Rd, Modesto, CA	Name:
	Street Address:
☐ **Precision Imaging** 1239 McHenry Ave, Modesto, CA	City: State: Zip:
	Phone: ( ) - Fax: ( ) -

Information to be Released:

Please indicate dates of service for records requested:

Beginning: _____ **Through:** _____

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

Purpose of Release

☐ Continuity of Care ☐ Personal Health Record ☐ Physician Request at Time of Visit

☐ Other (please explain):_____

HIM.0001

D Martin 2019 Revision: 03-Oct-2019 [7]
APP: Forms Committee: 17-Oct-2019
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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)

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