San Ramon Regional Medical Center

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Phone: 925-275-8263 Fax: 925-275-8209

Patient's Name: _____
Last **First** **Middle**

Home Address: _____

Telephone: _____ **Date of Birth:** _____

Date(s) of Hospital Service: _____

SPECIFY INFORMATION TO BE DISCLOSED:

☐ Admission Face Sheet	☐ Operative Report	☐ Lab Results	☐ Radiology Film/CD
☐ Consultation Report	☐ Progress Notes	☐ Respiratory Treatment Notes	☐ Cardiology Film/CD
☐ Discharge Summary	☐ Pathology Reports	☐ Rehab/Therapy Notes	☐ Billing Records/ Financial Information
☐ Emergency Dept. Report	☐ Radiology Reports	☐ Medication Record	
☐ History and Physical	☐ Cardiology Reports	☐ Mental Health Information	☐ Physician Orders
☐ HIV/AIDS Testing, Treatment, Diagnosis		☐ Other, please specify: _____	

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization.

- ☐ Information about mental health or mental retardation services
- ☐ Psychotherapy Notes created by a mental health professional
- ☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- ☐ Information about sexually transmitted diseases
- ☐ Information about alcohol or drug abuse treatment program services
- ☐ Information about sexual assault
- ☐ Information about child abuse and neglect

RECIPIENT: _____

Name of person or class of persons to whom San Ramon Regional Medical Center may disclose my health information:

SPECIFY MEANS OF DELIVERY: ☐ MAIL ☐ FAX ☐ EMAIL ☐ ELECTRONIC ☐ IN PERSON

RECIPIENT'S ADDRESS or FAX # or EMAIL:_____

TERM: **This Authorization will remain in effect (if left blank below, this authorization will remain in effect for 365 days or one year):**

- ☐ From the date of this Authorization until the _____ day of _____, 20____
- ☐ Until **San Ramon Regional Medical Center** fulfills this request.
- ☐ Until the following event occurs: _____
- ☐ Other: _____

PURPOSE: I authorize **San Ramon Regional Medical Center** to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s):

☐ The Disclosure is at my (patient's) request	☐ Disability Determination	☐ Personal Use
☐ Further Medical Care	☐ Attorney/Legal Investigation	☐ Insurance
☐ View Medical Records on Site	☐ Government Agency/Police	

I understand that San Ramon Regional Medical Center may charge me a per page fee for the copying services necessary to complete my request.

San Ramon Regional Medical Center

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Phone: 925-275-8263 Fax: 925-275-8209

I understand that once **San Ramon Regional Medical Center** discloses my health information to the recipient, **San Ramon Regional Medical Center** cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Texas law governing the use and disclosure of my health information.

I understand that **San Ramon Regional Medical Center** may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at **San Ramon Regional Medical Center**; except, however, if my treatment at **San Ramon Regional Medical Center** is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case **San Ramon Regional Medical Center** may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to **San Ramon Regional Medical Center's** Privacy Office at the address listed below. The revocation will be effective immediately upon **San Ramon Regional Medical Center**'s receipt of my written notice, except that the revocation will not have any effect on any action taken by **San Ramon Regional Medical Center** in reliance on this Authorization before it received my written notice of revocation.

I may contact **San Ramon Regional Medical Center's Medical Records Office** by mail at **6001 Norris Canyon Road, San Ramon, CA 94583, OR, by telephone at (925)275-8262 OR by email at srm-him@tenethealth.com**

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information.
By my signature, I hereby, knowingly and voluntarily authorize San Ramon Regional Medical Center to use or disclose my health information in the manner described above.

_____ _____

Signature or Patient **Date**

Note:
If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____

Signature or Authorized Personal Representative Relationship to Patient Date

Office Use Only

Identity of Requester Verified via: ☐ Photo ID ☐ Matching Signature ☐ Other specify: _____

Verified by:_____ Date: _____

Request Fulfilled by:_____ Date: _____ ACCT #: _____

Method: Mailed / Picked-Up by Patient / Fed Ex / Email / Electronic Portal

☐ Medical Record(s) for Date(s) Requested ☐ Billing Records

☐ Radiology CD / Cardiology CD ☐ Other: _____