Authorization for Use and Disclosure of Health Information

Physical Address:
3800 Janes Rd
Arcata, CA 95521-4742
Mailing Address:
PO Box 1115
Arcata, CA 95518-1115
Phone: (707) 822-3621
Fax: (707) 822-2366
www.MadRiverHospital.com

Patient Name: _____

DOB: _____ Date(s) of Service: _____ Phone_____

I authorize Mad River Community Hospital (or: _____)

and its affiliated sites to release to:

_____
(name and address of recipient)

The following health information maintained by Mad River Community Hospital:

❑ A) Dictated Reports; Discharge Summary; History and Physical; Operative Report; Consultation Report; Lab Tests; Radiology Report; Pathology Report; Emergency Room Reports;

❑ B) Only the following type(s) of information:

❑ Discharge Summary	❑ Outpatient Clinic Records	
❑ Inpatient Progress Notes	❑ Emergency Record	❑ Pathology Report(s)
❑ History & Physical	❑ Laboratory Test(s)	❑ Complete Medical Record
❑ Operative Report	❑ Radiology Report(s)	❑ Radiology Disk(s)
❑ Consultation Report	❑ HIV_____ *initial*	❑ Mental Health _____ *initial*

❑ Other(s): _____

PURPOSE: Requested by patient if no other box is checked, otherwise:

❑ Transfer of Care ❑ Continuity of Care ❑ Other_____

EXPIRATION

This authorization shall become effective immediately and shall remain in effect until: _____

If no date is given, the authorization will be valid for one year from the date of signing.

SIGNATURE:

_____

Signature (Patient/Representative) Date Time

_____

If signed by other than patient, print name and relationship.

(see other side for rights and restrictions) ⇨

RESTRICTIONS

Information disclosed pursuant to this authorization could be re-disclosed by the recipient 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 disclosure is obtained from me or unless such disclosure is specifically required or permitted by law. The protection does not extend to recipients outside the state of California.

YOUR RIGHTS

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address:

  Mad River Community Hospital, PO Box 1115, Arcata, CA 95518-1115
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have a right to receive a copy of this authorization (required if authorization is requested for the provider's use or disclosure of health information).
- I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.
- Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45C>F>R> Section 164.508(d)(l),(e)(2).
- The requestor is to complete this section of the form.

When this form is completed either:

a) deliver to Mad River Community Hospital ***along with a valid copy of your Photo ID*** from 8:30 AM to 4 PM Monday-Friday or,

b) fax ***along with a valid copy of your Photo ID*** to (707) 822-2366 or,

c) mail ***along with a valid copy of your Photo ID*** to the following address:
Mad River Community Hospital
Attn: Medical Records
PO Box 1115
Arcata, CA 95518-1115

d) e-mail a scanned copy ***along with a scanned valid copy of your Photo ID*** to the following e-mail address: *medicalrecords@madriverhospital.com*