Alameda Hospital
A member of Alameda Health System

# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Health Record Number: M_____
Date of Birth: _____/_____/_____ Account Number: V_____

**Failure to provide *all* information requested may invalidate this Authorization.**

## *USE AND DISCLOSURE OF HEALTH INFORMATION*

I hereby authorize the use or disclosure of the above named individual's health information as follows:
Persons/Organizations authorized to *use or disclose* the information: ❑ Alameda Hospital
❑ Other: _____
Persons/Organizations authorized to *receive and use* the information: ❑ Alameda Hospital
❑ Other: _____
Purpose of requested use or disclosure:
_____
Limitations, if any:_____
This Authorization applies to the following information to be used or disclosed:
Dates of Service: _____
❑ Discharge Summary ❑ History and Physical ❑ Consultation
❑ Surgery Report ❑ Pathology Report/slides ❑ OP Surgery Report
❑ Laboratory results from (date) _____ to (date) _____
❑ X-Ray/imaging reports from (date) _____ to (date) _____
❑ Minimum necessary (includes discharge summary, history and physical, consultations, physician progress notes, laboratory, diagnostic testing including radiology, nuclear medicine, cardiology, vascular medicine).
❑ Other (including dates): _____
❑ Entire record from (date) _____ to (date) _____

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I specifically authorize release of the following information (check as appropriate)
❑ HIV Test results ❑ Drug /Alcohol ❑ Mental Health Records
❑ I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental

health services, and treatment for alcohol and drug abuse. If this information is to be excluded, state the desired information to be excluded: _____

## *EXPIRATION*

This Authorization expires:

_____

[If no date or event is specified, the expiration will be in six months]

## *MY RIGHTS*

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing, signed by me or on my behalf, and delivered to the following address: Alameda Hospital, Health Information Management, 2070 Clinton Avenue, Alameda, CA 94501. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might 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.

    - *If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.*

- *Patients of federally-assisted substance abuse programs and patients whose records are covered by LPS may revoke an authorization verbally.*
- *4 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 45 C.F.R. Section 164.508(c)(4)).*

***SIGNATURE***

Date: _____ Time:_____ a.m./p.m.

Signature:_____Phone:_____
*(patient/representative/spouse/financially responsible party)*

If signed by someone other than the patient, state your legal relationship to the patient:

_____

Witness:

_____