Authorization Form Instructions

PATIENTS PLEASE INCLUDE A COPY OF YOUR GOVERNMENT ISSUED PHOTO ID AS WELL AS THE BEST CONTACT PHONE NUMBER WITH YOUR COMPLETED FORM

Please completely fill in ALL areas to include the following:

- **Patient Information:** Patient Name, Patient Date of Birth and Phone Number. Your Medical Record Number will be provided by our facility.

- **You Authorize:** Identify which facility your records are being requested from. For example, if you would like to receive your records from Highland Hospital check the box for Highland Hospital in this section.

- **To Disclose To:** Identify who is to receive the records. Include the name of the receiver, a business fax number or address to mail the records to. Please include a phone number for the recipient so that Alameda Health System (AHS) staff can contact them, if needed.

- **Dates of service and records needed:** Include a specific date or date range for the records you are requesting. Identify which records you are requesting by checking the appropriate boxes (check all that apply).

- **Purpose:** Indicate the reason why you are requesting your records.

- **Expiration Date:** This section is optional. If left blank, your authorization will be valid for one (1) year. For expiration shorter than one year, please indicate a specific date for the authorization to expire.

- **Signature:** Sign and date the request form. If signed by someone other than the patient, please attach copies of official legal documents that allow the individual to sign for the patient (i.e. Power of Attorney, Advanced Healthcare Directive).

ALAMEDA HEALTH SYSTEM

CR0050

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information, about you. Failure to provide *all* information requested may invalidate this Authorization.

PATIENT INFORMATION

Patient's Name: Last: _____ First: _____ M: _____

Date of Birth: _____ / _____ / _____ Phone Number: _____
Month *Day* *Year*

Medical Record Number: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

** Please check box next to facility authorized to **disclose** the information**

YOU AUTHORIZE:

☐ **Alameda Hospital & South Shore Rehab:** 2070 Clinton Ave., Alameda, CA 94501	Tel: (510) 814-4037 Fax: (510) 814-4352
☐ **Eastmont Wellness:** 6955 Foothill Blvd., Oakland, CA 94605	Tel: (510) 567-5700 Fax: (510) 567-5822
☐ **Hayward Wellness:** 664 Southland Mall Drive, Hayward, CA 94545	Tel: (510) 266-1722 Fax: (510) 266-1761
☐ **Highland, Fairmont or John George Hospital:** 1411 E. 31st St. Oakland, CA 94602	Tel: (510) 437-4469 Fax: (510) 437-5052
☐ **Marina Wellness and Surgical Associates:** 815 Atlantic Ave, Suite 100, Alameda, CA 94501	Tel: (510) 535-7363 Fax: (510) 864-1483
☐ **Marina Wellness Primary Care:** 947 Marina Village Parkway, Alameda, CA 94501	Tel: (510) 422-3400 Fax: (510) 749-0972
☐ **Newark Wellness:** 6066 Civic Terrace Ave., Newark, CA 94560	Tel: (510) 505-1600 Fax: (510) 494-7240
☐ **San Leandro Hospital:** 13855 E. 14th St., San Leandro CA 94578	Tel: (510) 667-4575 Fax: (510) 895-1971

TO DISCLOSE TO: _____
(Persons/organizations authorized to receive the information)

At the following address: _____ _____
(Street) (City, State and Zip Code)

Phone: _____ Fax: _____

Original - MR Copy - PATIENT
FILE IN MEDICAL RECORD

ALAMEDA HEALTH SYSTEM

CR0050

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

USE AND DISCLOSURE OF HEALTH INFORMATION, *continued*

I authorize disclosure of the information described below: (check all that apply)

Dates of Service: _____

☐ Pertinent Information **(dictated physician reports, lab and radiology)**	☐ Pathology Report	☐ Discharge Summary
☐ History and Physical Examination	☐ Entire Medical Record	☐ Progress Notes
☐ Laboratory test Results	☐ Consultation Reports	☐ Operative Report
☐ Emergency Room Record	☐ X-Ray Films/Reports/Digital Images	☐ Other: _____

Check the boxes below if you want this release to include the following information, Otherwise, this information will be excluded.

☐ **Mental Health Treatment Records** ☐ **Addiction Medicine Treatment Records** ☐ **HIV Test Results**

PURPOSE

Purpose of requested use or disclosure: ☐ Patient request; ***OR*** ☐ Other:

EXPIRATION

This authorization shall become effective immediately and shall remain in effect until (enter specific date): _____

If no date is given the authorization expires one year from date of signing.

SIGNATURE

Signature _____

(Patient/representative/spouse/financially responsible party)

Date:_____Time_____ ☐ am ☐ pm

If signed by someone other than the patient, print name and legal relationship to the patient:

Print name/relationship: _____ / _____

ALAMEDA HEALTH SYSTEM

CR0050

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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. My revocation must be in writing, signed by me or on my behalf, and delivered to this address:

_____

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. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

PRINT SAVE AS RESET