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

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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

USE AND DISCLOSURE OF HEALTH INFORMATION, *continued*

Hospital and Dates of Service: _____ I authorize disclosure of the information described below: *(check all that apply)*

☐ 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: _____ / _____

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YOU AUTHORIZE:

PRINT SAVE AS RESET