Kaweah Delta
HEALTH CARE DISTRICT
400 W. Mineral King − Visalia, CA 93291−6362 − 559.624.2000

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. **Failure to provide all information requested may invalidate this Authorization.**

USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name _____

Address _____

City _____ State _____ Zip Code _____

Phone (____)_____ Alternate Phone (_____)_____

DOB _____ Last 4 Digits of SSN _____

I hereby authorize _____ (Name of physician, hospital or health care provider) to disclose to:

Name of Requestor: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____)_____ Fax:(____)_____

Purpose of requested disclosure:

❑ Medical Care ❑ Personal ❑ Other: _____

Date of Service: _____

This authorization applies to the following information:

❑ History and Physical
❑ Discharge Summary
❑ Mental Health Treatment Info
❑ Operative Report
❑ Office/Clinic Note
❑ Immunization Record
❑ Wellness Check (Physical)
❑ Dialysis Records
❑ Labs/X−Rays
❑ HIV Treatment
❑ Alcohol/Drug Treatment
❑ Emergency Department Report
❑ Genetic Information
❑ Other: _____

Method of Release:

❑ CD ❑ Flashdrive ❑ Paper ❑ Mailed ❑ Email

If emailed to patient, email address: _____

❑ Pick up by patient

❑ Pick up by other than patient:
Name: _____

EXPIRATION

This authorization expires (one year from today's date): _____

NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this authorization. I have the right to receive a copy of this authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address:

Kaweah Delta Health Care District
Health Information Management
400 W. Mineral King Avenue
Visalia, CA 93291

My revocation will be effective upon receipt, but will be limited to the extent that the requestor or others may have responded to this authorization.

Neither treatment, payment, or eligibility for benefits will be conditioned on my providing or refusing to provide 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.

I may inspect or obtain a copy of the health information that I am being asked to authorize use or disclosure.

I understand that this may include ALL medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition, including psychological or psychiatric impairment, drug abuse and/or alcoholism, and HIV results.

If this box ❑ is checked, the requestor will receive compensation for the use or disclosure of my information.

SIGNATURE

Patient: _____ Signature: _____ Date/Time: _____

☐ Signed by other due to patient's condition at time of service

Other's Signature: _____ Date/Time: _____ Relationship: _____

Attending must authorize release of Psychiatric and Chemical Dependency records:

Please check one: ❑ Authorize Release ❑ Deny Release

			am / pm
Physician	Signature	Physician #	Date/Time