SIERRA VISTA HOSPITAL AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

FOR THE RECIPIENT OF THE INFORMATION:

I hereby authorize: Sierra Vista Hospital

8001 Bruceville Road

If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consented of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Note: California Law also prohibits further disclosure of medical information, including alcohol or drug abuse treatment records and medical and /or mental health records, unless further use or disclosure is expressly permitted by obtaining a new written authorization for release of information from the person to whom the information pertains.

Sacramento, Ca 95823 PH: 916 288 0300 Fax: 916 288 0454 To receive, use or disclose health information and records obtained during the course of the treatment of: Patient Name: ______Date of Birth: _____ Address: _____Phone #: ____ Social Security #: _____ 1. The information is to be used or disclosed to the following persons or organizations: To release to Person/ Entity: ______ Relationship: _____ Address: Phone #: _____ Fax #: ____ 2. Dates of treatment provided on or around (insert dates):_____. If this line is left blank, the treatment dates covered by this authorization are from most recent admission to discharge and claims resolution. I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for physical and mental illness, alcohol/drug abuse; HIV/AIDS test results or diagnoses. (Refer page 2 for charges) The information to be used or released includes: __Discharge Summary __History & Physical Exam __Psychiatric Admission History

__Progress Notes __Medication Records __Laboratory/X-ray report __Billing/Financial Records __Administrative letter for dates of treatment

_All Records __Free copy (Discharge Summary, H&P, Psychiatric Admission History)

Purpose: __at the request of the patient __other: ____

Charge: I understand I will be charged **\$0.25 per page plus \$7.50 processing fee per record for requesting copies of all record** or request **Discharge Packet** (discharge summary, H&P exam and Psychiatric Admission History) for **free of charge**.

Method of delivery of requested records: Mail Pick up - provided Phone # to sch	hedule pick up:
This authorization is limited to only the information that or disclosed to the persons/facilities named herein. I he from all legal responsibilities or liability that may armedical records and other health information in reliance	ereby release Sierra Vista Hospita ise from the use or disclosure o
1. Expiration : I understand that unless I revolution authorization will automatically expire 180 days signed.	
 Re-disclosure: I understand that information us this authorization may no longer be protected by re-disclosed by the receiving party. 	
3. Refusal to Sign : I understand that I may refuse Sierra Vista Hospital will not condition treatment on whether I sign this authorization.	_
 4. Revocation: I have the right to make a written reinformation at any time, although I understand information already used or disclosed under this section. 5. Copy: I understand that I have the right to receive 	d that I cannot do anything about authorization.
Certification: I certify that I am The patient and the Identification that I have provided The Patient's authorized representative, and the Iden that I have provided is true and correct. My relation to	tification and proof of authority
Signature:	
Minors: I understand that minors 12years of a authorization along with their legal parent/g	_
Patient Signature (required if Adolescent)	Date
Parent or Legally Authorized Representative	Date
Staff Member/Witness Signature (Print Last Na	ame) Date