

Instructions | Authorization for Health Information Form

Note: IF THE REQUIRED FIELDS BELOW ARE NOT COMPLETED THE AUTHORIZATION WILL BE RETURNED.

Section A: Fill in your patient's name, DOB, MRN and telephone number.

Example: Name: John Doe DOB: 01/01/1900
Telephone: (234) 567-8910 MRN: 12345678 (If MRN is not known leave blank)

Section B.1: Specify what information you want disclosed by checking *and* initialing your name.

Example: J.D. Records relate to a specific Date of Service and not entire records: 01/01/2010

Example: J.D. Further specify which records (provide a description): ED Visit Notes

If you are requesting the entire medical record mark the box below.

Example: J.D. Entire medical record.

Section B. Page 2: IF PATIENT DOES NOT HAVE ANY SENSITIVE INFORMATION LEAVE PAGE 2 BLANK.

The items on page two are classified as sensitive information (Mental Health, Family Planning, Hereditary Disorder and HIV/AIDS testing) and the patient must check and initial applicable box to release specific sensitive information.

Section C. Page 3: Recipient: The name and address of the person or organization to whom records should be sent.

Example: Recipient: John Doe, 123 Fake St, Redwood City, CA, 94063

Section D: Purpose of Disclosure: Check *one* of the appropriate boxes below.

Example: Check here if you are the patient and you do not want to provide the reason.

Example: Check here if the release is *not* to the patient and provide the reason for release here.

Section E. Delivery Method: Check *one* of the appropriate boxes.

Example: Check here if you would like the health information mailed to recipient above.

Example: Check here if you will pickup health information at the HIMS Department (in Redwood City).

Example: Check here if you are not requesting a copy of your health information, but would like to inspect your records.

Example: Fax to _____ (print fax number) **Records are faxed only in emergency situations to healthcare providers.**

Section F. Expiration Date: If you chose to have the authorization expire on a specific date you may do so, however the box may be left blank. If the box is left blank the authorization will automatically expire one year after date of signature.

Section I: At the bottom of the page make sure to **print your name, home address, and sign and date the authorization.**

Note: *If patient is not signing authorization, family member/representative must provide legal documentation to establish authority to sign on patient's behalf, unless patient is a minor.*