## **AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION** RIDGECREST REGIONAL HOSPITAL

Address: 1081 N. China Lake Blvd. Ridgecrest CA, 93555 Phone: 760-499-3668 Email: MedicalRecords@rrh.org

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.

If you have not received a response to your request within 10 business days, please call us immediately at (760) 499-3668

USE AND DISCLOSURE OF HEALTH INFORMATION
Patient's Name: Date of Birth: Medical Record # Current Address: Phone Number: Cell #:
Phone Number: Cell #: Use of disclosure: I hereby authorize Ridgecrest Regional Hospital to disclose the information listed below to: ( <i>List the person/organization authorized to receive this information.</i> )  Name of Person or Facility:
Address: City: State: Zip: Phone #: ( ) Fax #: ( )
FORMAT TO RECEIVE THE RECORDS:
Select Format: □ Paper □ Electronic
Select Method:   CD   Email:   Mail to address above:   Self Pick up:   Fax:   Fax:
PURPOSE OF DISCLOSURE
☐ Personal Use ☐ School ☐ Disability/Social Security ☐ Continued Medical Care ☐ Insurance ☐ Legal ☐ Military ☐ Other (Specify):
TYPE OF INFORMATION TO BE DISCLOSED
Specify Date(s) of treatment: From: To:    Hospital: Pertinent Information from Hospital Visit: (Discharge Summary, History and physical, ED Report, Operative Report, Consultations, Exam results (Lab, Radiology, Cardiology, path), EKG/EEG, Sleep Study)    ED Visit
* I specifically authorize release of the following information: □ HIV test results □ HIV test □ Alcohol/drug treatment information □ Mental health treatment information
A separate authorization is required to authorize the disclosure or use of psychotherapy notes.



AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL **INFORMATION** 

**FFAUTHDISINFO** 

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Address: 1081 N. China Lake Blvd. Ridgecrest CA, 93555 Phone: 760-499-3668

**EXPIRATION** 

Email: MedicalRecords@rrh.org

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This authorization expires (not to exceed 12 months):// (month/day/year)  If left blank, this Authorization will expire one year from the date the Authorization is signed.
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, but I must do so in writing and submit it to the following address:
Ridgecrest Regional Hospital Health Information Management 1081 N. China Lake Blvd., Ridgecrest, CA 93555. Email: MedicalRecords@rrh.org
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 HIPAA.
SIGNATURE (Sign Below)
Date: Time: AM/PM
Signature:(Patient/Representative/Spouse/Financially Responsible Party)
State your legal relationship if signed by someone other than the patient:
Witness:
RELEASE OF DOCUMENTATION (Staff Use Only)
Picked Up By: ID Checked: Driver's License: Other: Date:



**AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION** 

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