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 #: ______________________
Use of disclosure: I hereby authorize Ridgecrest Regional Hospital to disclose the information listed below to: (***List the person/organization authorized to receive this information.***)
Name of Person or Facility: ____
Address: ____ City: ______________________________
State: ____ Zip: ________ Phone #: ( )_______________ Fax #: ( )_________________

FORMAT TO RECEIVE THE RECORDS:

Select Format: ☐ Paper ☐ Electronic

Select Method: ☐ CD ☐ Email: ________________________________ Fax: ☐ ____________
Mail to address above: ☐ Self Pick up: ☐

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** ☐ **Surgical Visit** ☐ **Radiology Film/CD** ☐ **Entire Medical Record**
☐ **Other** (Specify) ____
Clinics: ☐ Office Note ☐ Test Results ☐ Dental ☐ Other______

* 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.

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EXPIRATION

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: ____
Released by: ____________________________ Date: ____________

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION