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.

## USE AND DISCLOSURE OF HEALTH INFORMATION

Patient's Name: _____ MR# _____

DOB: _____ Date(s) of Service From: _____ To _____

Email Address: _____

The following person or facility is authorized to **receive** my Protected Health Information:

Name of Person or Facility: _____

Address: _____ City _____ State _____ Zip _____

Phone # (  ) _____ Fax #(  ) _____

## PURPOSE OF DISCLOSURE

__ Personal Use __ School __ Disability/Social Security __ Other (Specify)

__ Continued Medical Care __ Insurance __ Legal __ Military

## TYPE OF INFORMATION TO BE DISCLOSED

| | | | | |
|---|---|---|---|---|
| __ Face Sheet | __ X-Ray Image | __ H&P | __ Path Report | __ Other |
| __ ER Record | __ X-Ray Dictation | __ Consultation | __ Entire Record | _____ |
| __ ER Dictation | __ EKG/EEG | __ Op Report | __ Physician Orders | _____ |
| __ Lab | __ D/C Summary | __ All Dictation | __ Sleep Study | _____ |

*** I specifically authorize release of the following:** ___ HIV test results

__ Alcohol/drug treatment information __ Mental health treatment information

*A separate authorization is required to authorize the disclosure or use of psychotherapy notes.*

## EXPIRATION

This authorization expires (not to exceed 12 months) _____ / _____ / _____ (month/day/year)

## 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: 1081 N. China Lake Blvd., Ridgecrest, CA 93555. 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. 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.

## SIGNATURE (Sign Below)

**Date:** _____ **Time:** _____ **a.m./p.m.**

**Signature:** _____

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: | | Picked Up By: |

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

INFORMATION FOR PATIENTS
Release of Copies of Medical Records
(760) 499-3668

General Information

California State laws and Federal Regulations allow for release of medical information with an appropriate authorization from the patient, parent or patient representative. There are specific types of information in which release is limited or restricted, including but not limited to psychiatric, chemical dependency, HIV results, adoptions, etc.

- Identification is required. If someone other than the patient signs the consent, supporting identification or papers may be necessary.

Business Hours

The Health Information Management Department (Medical Records) is open to the public from 8:00 AM- 4:00 PM Monday through Friday, except for holidays. Special arrangements may be made for after-hours business transactions if an emergency. Please call the Health Information Management (HIM) Department during business hours to arrange this.

Response Time

We make every effort to respond in a timely manner to your request for release of information. California State Law allows medical providers ten (10) business days after written authorization to furnish records to any requestor. However, Ridgecrest Regional Hospital's turnaround time is usually less than ten days, depending upon the volume of requests at any certain time.

Copies for Continuing Care

Your continuing care is important. Information that is mailed or faxed directly to a physician or hospital will be processed free of charge. Although we work with you to have information available at medical appointment time, we appreciate any advanced notice that you can give us.

Patient Access/Request for Copies

California Health & Safety Code 1795 et. seq. makes provisions for patients, parents or patient representative to have access to their records, except in very limited situations. Please refer any specific questions to the Release of Information Clerk.

Laboratory Results

- Availability of lab tests varies. The Health Information Management Department can access most lab results after the tests have been computed and entered into the lab system.
- Reports that are sent out to other labs for processing may take from several days to several weeks.

Radiology Results

- Radiology reports become part of the medical record but the actual radiology images do not. Copies of the images may be requested from the Radiology Department after completion of a release of information authorization.

Charge

First request for copies of a visit is free. Additional requests for the same date of service are $0.25/page.

Payment of Charges

Payment is required at time copies are picked up or prior to mailing. Payments must be made in full either by cash or check (with proper identification) payable to Ridgecrest Regional Hospital. Copies of records will be held for 30 days, unless you make other arrangements. Copies that are not picked up within 30 days will be destroyed and the charges listed above will apply for additional requests for that date of service. Please note any special instructions regarding explanation of charges on you consent, such as a quote prior to copying or a notification call if charges exceed a certain dollar amount.