See attached instructions for help with completing this form

Eastern Plumas Health Care
"People Helping People"

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Please mail or fax a copy of this Authorization form to:
Eastern Plumas Health Care Attention Medical Records
500 1st Ave
Portola, CA 96122
Phone: 530-832-6542
Fax: 530-832-1438

There may be fees incurred for this service.

Patient Information (*Tell us about the patient*)

Patient Name: _____ DOB: _____ MRN: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email (optional): _____

Type of Access Requested (*Please check ONLY one*)

☐ Paper Copy ☐ CD ☐ Inspection Only
☐ Email (**not** encrypted) *(Note: If you would like us to send information over email not encrypted, this increases the risk that information could be read by an unauthorized third party.)*

Delivery Method (*Please check ONLY one*)

☐ Mail ☐ Email ☐ Fax ☐ Pick-Up

Purpose of Requested Use or Disclosure (*Tell us how you will use the records*)

☐ Continuity of Care – Appointment Date with Physician: _____
☐ Patient ☐ Insurance ☐ Other: _____

Authorization – I hereby authorize:

_____
(Name of hospital, physician, healthcare provider)

_____
Address City State Zip

_____
Phone Fax

To release my health information to: ☐ Check this box if same as patient listed above. ***OR***

_____
(Name of hospital, physician, healthcare provider, other)

_____
Address City State Zip

_____
Phone Fax

Information Disclosure (*Tell us what information you need*)

Information to be disclosed for the following date range _____ **to** _____:
☐ Hospital Records (Inpatient and Outpatient)
☐ Clinic (Specify Provider Name): _____
☐ Radiology Report(s) Only
☐ Radiology Images (Specify): ☐ X-ray ☐ Ultrasound ☐ CT scan ☐ MRI ☐ Mammography
☐ Laboratory Test(s) Only
☐ Other: _____

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Please mail or fax a copy of this Authorization form to:
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Portola, CA 96122
Phone: 530-832-6540
Fax: 530-832-1438

Special Authorization *(Tell us if we have permission to release the following sensitive information)*

I specifically authorize release of the following information:

- ☐ HIV test results _____ (initial)
- ☐ Mental Health _____ (initial)

Expiration

This authorization shall become effective immediately and shall remain in effect for one (1) year from the date signed unless a different date is specified here: _____

Restrictions

California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

Your Rights

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address:
  EASTERN PLUMAS HEALTH CARE ATTENTION MEDICAL RECORDS
  500 1ST AVE
  PORTOLA, CA 96122
- My revocation will be effective upon receipt, but will have no impact on uses or disclosure made while my authorization was valid.
- I have a right to receipt a copy of this authorization (required if authorization is requested for the provider's use or disclosure of health information).
- I may inspect and obtain a copy of the health information of which I am authorizing the use or disclosure of my health information.

Signature *(As required by law)*

SIGNATURE: _____ Date: _____ Time: _____

(Patient/Legal Representative)

If signed by other than the patient, print name and relationship:

Name: _____ Relationship: _____

Office Use Only Identification verified by (name): _____

Verified by (method): ☐ Photo ID ☐ Matching Signature ☐ Other: _____