Eastern Plumas Health Care
"People Helping People"

Portola Hospital
500 First Ave.
Portola, CA 96122
Tel: 530.832.6540
Fax: 530.832.1438

Loyalton SNF
700 Third St.
Loyalton, CA 96118
Tel: 530.993.1225
Fax: 530.993.4878

Clinics and Services

Portola Medical & Portola Dental
480 First Ave
Portola, CA 96122
Tel: 530.832.6600
Fax: 530.832.5968

Graeagle Medical
PO Box 1024 7597 Hwy 89 Graeagle, CA 96103 Tel: 530.836.1122 Fax: 530.836.1642

Loyalton Medical
725 Third St
Loyalton, CA 96118
Tel: 530.993.1231
Fax: 530.993.4857

Pine Street Medical & Dental
145 N Pine St
Portola, CA 96122
Tel: 530.832.4425
Fax: 530.832.1058

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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Patient Name_____DOB_____

I hereby authorize:_____

To release to (Persons/Organizations authorized to receive the information)
(Address, street, city, state, zip code):_____

_____

Phone:_____ Fax:_____

For the purpose of:_____

The following information:

- All health information pertaining to my medical history, mental or physical condition and treatment received; OR
- Only the following records or types of health information (including any dates):

_____

_____

_____

I specifically authorize release of the following information
(check as appropriate):

- Mental health treatment information_____(initial)
- HIV test results___(initial)
- Alcohol/drug treatment information_____(initial)

A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.

This authorization expires on (unless otherwise revoked, this authorization will expire 180 days from the date authorized):_____

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment on eligibility for benefits.
- I may inspect (by appointment) or obtain a copy of the health information ($.25 per page) 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: Eastern Plumas Health Care, Health Information Management Department 500 First Ave, Portola, CA 96122

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 redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPPA). 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.

Date:_____ □ Mailed □ Picked Up □ Faxed

_____

Signature of patient or legal representative

_____

If signed by a person other than the patient, indicate relationship

_____

Records released by

Identity verified by (Must produce photo ID) □ Drivers License □ Other-Specify