



# Eastern Plumas Health Care

"People Helping People"

**Portola Hospital/  
SNF**

ALL MEDICAL  
RECORDS REQUESTS  
500 First Ave.  
Portola, CA 96122  
530.832.6540  
Fax: 530.832.1438

**Loyalton SNF**  
700 Third St.  
Loyalton, CA 96118  
530.993.1225

## Clinics and Services

**Portola Medical  
Clinic**  
480 First Ave  
Portola, CA 96122  
530.832.6600

**Portola Dental Clinic**  
480 First Ave  
Portola, CA 96122  
530.832.6602

**Graeagle Medical  
Clinic**  
7597 Hwy. 89  
Graeagle, CA 96103  
530.836.1122

**Loyalton Medical  
Clinic**  
725 Third St  
Loyalton, CA 96118  
530.993.1231

**Pine Street Medical  
Clinic**  
145 N Pine St  
Portola, CA 96122  
530.832.4425

## 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