Completion of this document authorizes the disclosure and / or use of health information, about you. Failure to provide *all* information requested may invalidate the Authorization. Mail *the completed form to*: *Washington Health Medical Group* 39300 Civic Center Dr., *Suite 370 Fremont CA 94538. Fax 510-608-6055*

Patient name: _____

Date of Birth: _____ Date(s) of Treatment: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

☐ I hereby authorize Washington Health Medical Group to release to:

☐ I hereby authorize _____ to release to:

Name of Agency / Facility / Person: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: (_____) _____ FAX: (_____)

_____ the following information:

a. ☐ Disch Summary ☐ History & Physical ☐ Operative / Proc Report
☐ Pertinent Info Packet ☐ Complete Medical Record

☐ Other _____

b. I specifically authorize release of the following information (check if applicable):

_____ Mental Health Treatment Information
_____ HIV Test Results
_____ Alcohol / Drug Treatment Information

PURPOSE

Purpose of requested use or disclosure:

☐ Attorney / Legal ☐ Continuing Medical Care ☐ Insurance

☐ Patient Access ☐ Other _____

Office Use Only
☐ Faxed
☐ Mailed
☐ Picked Up
Date _____

3170 MRA 441 (4/6/17)

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Washington Health Medical Group

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This Authorization expires 30 days from the date this authorization is signed.

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I may inspect or obtain a copy of my requested health information and understand I will be charged a fee of *up to .25¢ per page.*

I may revoke this Authorization at any time, but I must do so in writing and submit it to Washington Hospital Healthcare System — HIM Department 2000 Mowry Avenue, Fremont, CA 94538.

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 the Authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure may no longer be protected by the state or federal confidentiality laws. However, California law prohibits the re-disclosure of medical information without obtaining a new authorization or unless otherwise required by law.

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Date: _____ Time: _____am / pm

Signature: _____

(Patient / representative / spouse / financially responsible party)

Printed name: _____

If signed by someone other than the patient, state your legal relationship to the patient:

_____

Witness: _____