DATE:

PATIENT NAME:

BIRTHDATE:

ID VERIFICATION (TYPE):

ID VERIFIED BY:

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize:____________________________________________
(Name of person or facility which has information)

to release health information to: ____________________________________
(Name of person or facility to receive health information and full address)

____________________________________________________
Street address City State Zip Code

☐ Check this box to authorize exchange between the persons/organizations listed above.

**The purpose of this release is for (check one or more):**

☐ Continuity of care or discharge planning

☐ At the request of the patient/patient representative ☐ Other (state reason) ____________________

**Please specify the health information you authorize to be released. Please check all that apply.**
**For dates of service:** ________________________________________

☐ **Emergency Room Visit** (e.g. ED provider notes, radiology reports, lab and diagnostic, consults and procedure notes)

☐ **Entire Hospital Record** (e.g. History and physical, consult, operative report, discharge summary, lab, radiology reports, nursing notes, progress notes)

☐ **Clinic or Office Visit** (e.g. Progress notes, office notes, procedure notes, operative notes, lab, diagnostic and radiology reports)

☐ **Other Records** *(not listed above, please specify type):* ________________________________

**Delivery Method** *(please select one):* ☐ Mail ☐ Pick-up by Participant
☐ Pick-up by Personal Rep Name ____________________________

**The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:**

☐ Information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).

☐ Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, *et seq.*)

☐ Release of HIV/AIDS test results (Health and Safety Code §§120980 (g)).

☐ Release of genetic testing information (Health and Safety Code §§124980 (j)).

**EXPIRATION OF AUTHORIZATION**

Unless otherwise revoked, this Authorization expires________________(insert applicable date or event).
If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

____________________________ ____________________________
Print Name Signature (Patient, Parent, Guardian)

____________________________ ____________________________
Patient Phone Number (Reason Patient unable to sign)

____________________________ ____________________________
Date Time Name & Relationship to Patient (Parent, Guardian, Conservator, Patient Representative, Interpreter)

**Requested format:** ☐ Paper

**NOTICE**
IIH and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentially laws.

## Return Completed Authorization To:

Bakersfield PACE - Medical Records
1800 Height Street
Bakersfield, CA 93305
Fax: (885) 621-3928

**YOUR RIGHTS**
This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to Medical Records. The revocation will take effect when PACE receives it, except to the extent PACE or others have already relied on it. You are entitled to receive a copy of this Authorization.