Authorization To Disclose Health Information From SMHD

Post Office Box 660 - 85 Sierra Park Road - Mammoth Lakes, CA 93546 - 760-934-3311 - Fax 760-924-4029 - www.mammothhospital.com

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION FROM SMHD

I hereby authorize SMHD to disclose the following from the health records of:

Patient Name: ______________________________ Date of Birth: ____________

Address: ____
(Street) (City) (State) (Zip)

Phone:( ) ____________ Cell:( ) ______________ Fax:( ) ______________

Covering the period of healthcare from ________________ to ________________

Information to be disclosed (check all that apply): ☐ Clinic visit(s) ☐ Hospital

- ☐ Complete Health Record
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Operative Reports
- ☐ Physician Orders
- ☐ Progress Notes
- ☐ Consultation Reports
- ☐ Medical Imaging on Compact Disc ($16.00 fee)
- ☐ Laboratory Test Results
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Other (please specify)____

I understand that this will include information relating to (check all that apply):

- ☐ Treatment for Mental Health
- ☐ AIDS / HIV infection
- ☐ Treatment for alcohol abuse
- ☐ Treatment for drug abuse

This information is to be disclosed to:

______________________________________ ____________________
(Name of Individual Or Organization TO RECEIVE Information) Phone

____
(Address) (City) (State) (zip)

- I understand this information will be used for: ______________________________
- I understand that this authorization expires automatically one (1) year from the date indicated below, and that I may revoke this authorization at any time as explained in Mammoth Hospital's Notice of Privacy Practices except to the extent that action has already been taken on it.
- I have a right to receive a copy of this authorization.
- I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

____
Signature of Patient or Legal Representative Date

____
Print Name of Requestor If not patient, state relationship

If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. California law prohibits recipients of your health information from re-disclosing such information except with your written authorization or as specifically required or permitted by law.