



RI0050
 Authorization To Disclose Health
 Information From Southern Mono Healthcare District

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize **Mammoth Hospital** 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):

- | | | |
|--|--|--|
| <input type="checkbox"/> Emergency Room record | <input type="checkbox"/> Laboratory Test Results | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Other _____ | |

<input type="checkbox"/> Medical Imaging Records <input type="checkbox"/> USB Flash Drive (\$16.00 fee) <input type="checkbox"/> Email or Mobile App (email required)(no fee)(fastest method)	<input type="checkbox"/> Complete Health Record (first 25 pages are free) (.15 cents per page fee, plus postage, if applicable) <input type="checkbox"/> Complete Health Record Emailed Encrypted Secure (email required) (No fee)
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I understand that this will include information relating to (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Treatment for Mental Health | <input type="checkbox"/> Treatment for alcohol use |
| <input type="checkbox"/> AIDS / HIV infection | <input type="checkbox"/> Treatment for drug use |
| <input type="checkbox"/> Sickle cell anemia testing | <input type="checkbox"/> Genetic testing |

This information is to be disclosed to: (Name of Individual or Organization TO RECEIVE Information)

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

Phone: _____ Fax: _____ Email: _____

- 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.