AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient:_____________________________________ Date of Birth:______________

Other Names: _____________________________ Telephone Number: ___________________

Address: _________________________________ City/State/Zip: _______________________

Medical Record or Account #:____
(Facility use only)

I AUTHORIZE:

- ☐ **Woodland Clinic Medical Group**
  1207 Fairchild Court
  Woodland CA 95695
  Dr. ______________________
- ☐ **Barba/Bringhurst, MD**
  239 W. Court Street, Suite B
  Woodland CA 95695
  Dr. ______________________
- ☐ **Woodland Clinic - Davis**
  2660 W. Covell Blvd.
  Davis CA 95616
  Dr. ___________________

TO DISCLOSE TO: ____
(Persons/organizations authorized to receive the information)

at the following address:____
(street, city, state and zip code)

☐ **THE FOLLOWING RECORDS,** specific types of health information, or records for the date(s) of treatment as specified:

DATES OF SERVICE: ____

- ☐ Physician Notes
- ☐ Nurse Notes
- ☐ X-ray Reports
- ☐ Laboratory Tests
- ☐ Physical Exam
- ☐ Discharge summary
- ☐ Consultation Reports
- ☐ Operative Reports

☐ Other: ____

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☐ *THE FOLLOWING INFORMATION* contained in the records specified below **(Initial applicable lines and boxes below):**

____Mental health or developmental disability treatment records (excludes "psychotherapy notes")

____Substance abuse treatment records

____HIV test results (This authorizes disclosure of laboratory test results only. **Note that your records may include information concerning your HIV status <u>even</u> if you do not check this box.)**

☐ **ALL RECORDS** regarding my treatment, hospitalization, and outpatient care.
A separate authorization is required for the use or disclosure of psychotherapy notes or research health information.

PURPOSE: The-Purpose and limitations (if any) of the requested use or disclosure is:

☐ At the request of the patient or personal representative; OR

☐ Other: ____

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified: ______________________________
(insert date)

MY RIGHTS:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
  I may revoke this authorization at any time, but I must do so in writing and submit it to the following address *Woodland Healthcare, Release of Information Dept. 1207 Fairchild Ct., woodland CA. 95695. 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 re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

SIGNATURE:____________________________________ Date:______________________
(Patient or personal representative)

____________________________________ Print name of personal representative

____________________________________ Relationship to patient

Patient/Representative identification Verified. Initials:__________ *Dept:*____________________

⇨ PICTURED I.D. MUST BE PRESENTED ⇦