San Joaquin General Hospital
500 W. Hospital Road
French Camp, CA 95231
(209) 468−6000

AUTHORIZATION for RELEASE of INFORMATION

I, _____, hereby authorize
Patient or Legal Representative

San Joaquin General Hospital and Clinics to use or disclose my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal policy regulations.

Patient Name: _____ Med Rec/ID Number: _____

Date of Birth: _____ Sex: _____ SSN: _____

Persons/organization providing the information: Persons/organization receiving the information:

(From)	(To)
San Joaquin General Hospital 500 W. Hospital Road	Name of organization receiving records.
French Camp, CA 95231 Phone: 1-209-468-6646	Address of organization.
Fax: 1-855-698-4171 Email: sjghroi@sjgh.org	Phone&Fax number of organization.

Specific Medical Condition(s): _____
And/or
Specific Timeframe(s): _____

What is the purpose of the disclosure? _____

(**Note:** "at the request of the individual" is a sufficient description of the purpose when the patient initiates the authorization and elects not to provide a statement of purpose.)

A. Type of Records Needed:

☐ Discharge Summary	☐ Outpatient Clinic Notes	☐ History and Physical
☐ Progress Notes	☐ Operative Reports	☐ Emergency Record
☐ Laboratory Test(s)	☐ Prenatal/Delivery Record	☐ Pathology Report(s)
☐ Consultation Report(s)	☐ Complete Medical Record	☐ Radiology Test(s)

☐ Other _____

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B. I specifically authorize release of the following information (check if appropriate):

- ☐ Alcohol/Drug Treatment Records
- ☐ HIV test results

NOTE: A separate authorization is required to authorize the disclosure of psychotherapy notes.

☐ All of the records marked above pertaining to me.
☐ Only the records from _____ Date(s) of Treatment

Exceptions: _____

I understand that this authorization shall become effective immediately and shall remain in effect until _____ (six months from date of signature).

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I understand that I may revoke this authorization at any time by completing the Revocation of Authorization Form, obtained from the Medical Records/HIM Department. The revocation will only be effective from the date it is received in this office and will not apply retroactively.

I further understand that I have the right to refuse to sign this form and that my refusal will not result in SJGH conditioning the provision of health care with two exceptions:

1. If it is for disclosure of information created for research that includes treatment.
2. If it is for disclosure of information created for the sole purpose of disclosure to a third party.

I also agree to pay any fees associated with copying, reviewing and mailing the requested records. I understand that I am entitled to receive a copy of this authorization.

I have a right to receive a copy of this authorization. If this box is checked, ☐ the Requestor will receive compensation for the use or disclosure of my information.

Print Name: _____

Signature: Actual signature required. E-Signature not accepted. _____

Date: _____ Time:_____ am/pm

If signed by other than patient, indicate relationship: _____

Witness: _____