Name of Patient: Date of Birth:

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

To the Applicant: Please list the **names, addresses, and phone numbers** of all doctors, hospitals and chiropractors you have seen within the past 5 years. If you have been treated at a Kaiser facility, please specify the location and include your medical record number. **Please date and sign the authorization to release medical records or information.**

1._____
_____
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2._____
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8._____
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9._____
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10._____
_____
_____

I, the undersigned, authorize the above-named provider(s) of services to release to: _____, their authorized agent Castle Copy Service, attorneys, doctors, examiners or other classes of people that will evaluate your claim, all personal health information (PHI) as described; medical records, charts, notations, correspondence, reports, photographs, films, except as specifically excluded below:

_____

or, only the following records or types of health information and/or only on the specified dates (all if blank): Dates(s) of Treatment: _____Type of Treatment:_____

The disclosure of records authorized herein is required for the administration of Claim.

This authorization shall become effective immediately and shall remain in effect as long as is necessary for _____ to process your request, but nevertheless shall expire 2 years from the date of your signature.

This is an informed consent for the release of my records, and I have a right to receive a copy of this authorization upon request. A photocopy of this signed authorization shall be deemed as valid as the original.

Name of Patient: Date of Birth:

I understand that such information may be used by other parties necessary to participate in processing my claim. Such re-disclosure may no longer be protected by state or federal confidentiality laws. However, California law prohibits the re-disclosure of medical information without obtaining a new authorization or unless otherwise required by law. 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.

I have asked questions about anything that was not clear to me, and I am satisfied with the answers received.

This consent is subject to revocation by the undersigned in writing at any time by sending revocation to _____ and to the list of care providers listed on page 1, except to the extent that action has been taken in reliance herein, and if not earlier revoked, it shall terminate on the conclusion of my case without express revocation. If I revoke this authorization, it will not have any affect on actions taken by all parties in reliance of it before I revoked it.

I acknowledge that I am aware that the consequences of my not signing this authorization can include a delay in the processing/resolution of the (my) claim, a potential denial of the claim, or other consequences recognized by applicable state law and /or the insurance policy at issue. The healthcare facility will not condition treatment, payment, enrollment or eligibility for benefits upon securing a signed authorization.

I have private health insurance: ☐ Yes ☐ No Enter name of insurance company: _____

A specific authorization is required to disclose information regarding the following:

(Check box and sign to specify information to be disclosed)	*Signature*
[_] I consent to the release of any and all psychiatric treatment records.	_____
[_] I consent to the release of any and all drug / alcohol abuse records.	_____
[_] I consent to the release of any and all HIV Lab Test Results.	_____
[_] I consent to the release of any and all Genetic / Fertility records.	_____

I certify that this medical release authorization was printed in 14-point type when I signed it.
I have received a copy of this authorization.

Dated: _____ **SIGN HERE ➔** _____
(Signature)

_____ _____
(Name and relationship of party other than patient signing) (Patient name)

KAISER PERMANENTE®

Kaiser Foundation Hospitals
Permanente Medical Groups

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Patient Name: _____
Kaiser # _____ Date of Birth: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Phone #: ( ) _____
Email: _____

Kaiser Permanente will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.

This authorizes the following Kaiser Permanente Medical Center(s): _____

to disclose information as specified below for the following purpose(s): _____

Kaiser Permanente may disclose this information to:
☐ Check if same as above (disclosure to patient)
Recipient Name: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Phone #: ( ) _____ Fax #: ( ) _____
Email: _____

Copies of records or medical record information within the following dates: _____ **to** _____

☐ Both Hospital and Medical Office Records ☐ Medical Office Records ☐ Hospital Records
☐ Records limited to a specific provider: _____ or department: _____
☐ X-Ray films ☐ X-Ray Digital Images ☐ Laboratory Results

NOTE: Hospital and Medical Office records may include disclosure of information related to mental health, alcohol/drug, and HIV references contained within those records as part of this authorization.

The actual treatment records from mental health, or alcohol/drug departments, or results of HIV antibody tests are specifically protected, and will not be disclosed unless you sign below.

Mental Health department records → Signature: _____
Alcohol / Drug dependency treatment records → Signature: _____
HIV antibody test results → Signature: _____

Media Type: ☐ Electronic ☐ Paper **Delivery Preference:** ☐ Email/Secure Portal ☐ Mail ☐ Pickup

DURATION: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here _____(date).

REVOCATION: You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

REDISCLOSURE: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA). California recipients are required to obtain your authorization before further disclosing this information.

If you are requesting a form to be completed, we may substitute a standardized version of the form that provides the same or similar information requested.

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

_____ _____ _____
Date Signature If not patient, print your name and relationship

SCAL: NS-9934 (6-12) SPANISH-NS-1614; CHINESE-NS-6274
NCAL: 90258 (REV. 6-12) SPANISH 01782-000; CHINESE 01782-002

ORIGINAL - DISCLOSING PARTY CANARY - PATIENT

3000 Q Street
Sacramento, CA 95816
(916) 733-3332 Telephone

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 Used: _____ **Telephone Number:** _____

Patient Address:_____
(Street city, state and zip code)

I AUTHORIZE: **MERCY MEDICAL GROUP - A SERVICE OF DIGNITY HEALTH**
(Facility or other provider)

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

at the following address:_____
(Street city, state and zip code)

the following information contained in the records specified below (check box and initial applicable lines 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 initial this line.)**

☐ **THE FOLLOWING RECORDS,** specific types of health information, or records for the date(s) of treatment as specified [check applicable box(es)]:

__Billing Records	__Emergency Room Reports	__Procedure Reports
__Consultation Reports	__History and Physical	__Progress Notes
__Discharge Summary	__Laboratory Tests	__X-ray Reports

__Date(s):_____
__Other:_____

☐ **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:

Revised: 02/01/04

___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: ***Attn: Facility Privacy Official 3000 Q Street, Sacramento, CA 95816.*** 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:*_____

Note: If the **substance abuse treatment** information is protected by federal confidentiality rules (42 C.F.R. part 2) the following prohibition of re-disclosure statements must be provided to the recipient of the information:

The federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Blue Shield of California and Blue Shield of California Life and Health Insurance Company

AUTHORIZATION FOR RELEASE OF !NFORMATION

Purpose: This form is used to authorize disclosure of protected health information that may be included in the records you are authorizing us to release.

SECTION A: Individual authorizing release of information

Name_____ Subscriber No._____
City_____ State_____ Zip_____

SECTION B: Records authorized for release

By signing this form you are authorizing and directing Blue Shield of California (BSC) and Blue Shield of California Life and Health Insurance Company ("Blue Shield Life") to release the following records that may contain protected health information (check all that apply):

- ☐ Explanation of Benefits
- ☐ Claims Submitted by Providers
- ☐ Other_____

_____

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Effect of this Authorization: Your protected health information will be disclosed to the persons/companies you have designated. Once disclosed, your information may no longer be protected by federal or state privacy laws.

Release Records To: [specify the name, address and telephone number of the person/company to whom we should release the records, and the purpose for the release]

_____
_____
_____
_____

SECTION C: Expiration and revocation

Expiration: This authorization will expire one year from the date this authorization form is signed.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to BSC and Blue Shield Life. I understand that revocation of this authorization will *not* affect any action BSC and Blue Shield Life have taken in reliance on this authorization before receiving my written notice of revocation.

Custodian of Records
Blue Shield of California / Blue Shield of California Life and
Health Insurance Company
Law Department
50 Beale St.
San Francisco, CA 94105

INDIVIDUAL'S SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming authorization of disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following and attach copies of documents demonstrating your right to execute this authorization.

Personal Representative's Name:

_____

Relationship to Individual:

_____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT

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. Fees to reproduce records may apply.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient:_____Date of Birth:_____

Other Names Used: _____Telephone Number: _____

Medical Record or Account#:_____

(Hospital use only)

I AUTHORIZE :_____

(Facility or other provider)

TO DISCLOSE TO: _____

(Persons/organizations authorized to receive the information)

at the following address:_____

(street, city, state and zip code)

the following information (check box and initial applicable lines below):

____Mental health records (excludes "psychotherapy notes")

____Substance abuse treatment records

____HIV related information and other communicable diseases.

____Genetic testing information

❑ **THE FOLLOWING RECORDS**, specific types of health information, or records for the date(s) of treatment as specified [check applicable box(es)]:

❑ Billing Records	❑ Emergency Room	❑ Procedure Reports
❑ Consultation Reports	❑ History and Physical	❑ Progress Notes
❑ Discharge Summary	❑ Laboratory Tests	❑ X-ray Reports

❑ Date(s):_____

❑ Other(s):_____

❑ **ALL RECORDS (Fee May Apply)**

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

Dignity Health.
St. Joseph's Hospital and Medical Center

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

ROI

Patient Label

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 event or end date is specified: _____

(insert date or event)

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:

Facility Privacy Officer
St. Joseph's Hospital & Medical Center
350 West Thomas Road, Phoenix, AZ 85013

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon 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 Arizona 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:*_____

Note: If the substance abuse treatment information is protected by federal confidentiality rules (42 C.F.R. part 2) the following prohibition of re-disclosure statements must be provided to the recipient of the information:

The federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Dignity Health.
St. Joseph's Hospital and Medical Center

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

ROI

Patient Label

Sutter Medical Foundation
A Sutter Health Affiliate

❑ Sutter Medical Group
❑ Sutter West Medical Group
❑ Sutter Neuroscience Medical Group, Inc.

Office Use Only	
NC	
App.	
Scan Date	

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ DOB _____ MR# _____

Type of Access Requested: ❑ Copies ❑ Inspection ❑ Verbal Consent

Authorization

I hereby authorize _____
name of hospital, physician, health care provider

_____
address city state zip

to use and/or disclose my health information.

to: _____
name of individual, organization, etc.

_____
address city state zip

Purpose of disclosing information: _____

_____

This authorization applies to the following information: _____

_____

❑ Provide only the following records or types of records (provide treatment dates):

	Date		Date
❑ H&P		❑ Special Tests	
❑ Discharge Summary		❑ Lab/X-ray	
❑ Consultation		❑ ER Records	
❑ Outpatient Records		❑ Other	

OR

All of my records from (enter dates) _____
(Note: HIV test results require a special authorization)

I understand that the information in my health record may include information relating to sexually transmitted disease, or acquired immunodeficiency syndrome (AIDS). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Expiration

This authorization will expire on (enter date or event) _____ or six months from the date of execution.

California Restrictions

California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

Your Rights

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment, payment or health plan enrollment or eligibility for benefits.
- I may revoke this authorization at anytime. My revocation must be in writing, signed by me or on my behalf, and delivered to Health Information Services Department at this facility.
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.

Redisclosure

I understand that if the recipient of my information is not a healthcare provider, a health plan or healthcare clearing house, or not an entity required to comply with federal or state health privacy regulations, my health information may be further disclosed by such recipient and my information may no longer be protected by state and federal laws.

I have a right to receive a copy of this authorization.

If this box ❑ is checked, a copy was requested and received. Initials _____

Phone #: Day X _____ Message _____

Patient Signature X _____ Date X _____

Personal Representative Signature _____

Relationship to Patient _____

Witness _____

Is there a charge for release of health information?

Yes, the copy services will charge you a fee. Please request the name and number of the copy service used by the care center.

ATTENTION RECIPIENT: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE.