



P.O. Box 9578 - South Lake Tahoe, CA 96158

Phone - (530) 542-3000

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure, receipt, and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.

Failure to provide all information requested may invalidate this Authorization.

Patient Name: _____ Phone #: _____
(print name)

Health Record Number: _____ Date of Birth: _____
(we will provide)

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize **Barton Memorial Hospital** (name of disclosing party) at: **P.O. Box 9578, South Lake Tahoe, CA 96158** to use or disclose the patient's health information as described below to the person listed below.

Health information is to be disclosed and used by: _____

Address: _____ (must complete address)

For the purpose(s) of requested use or disclosure:

- At the request of the individual
- Insurance
- Attorney
- Continued Care: (please specify) _____
- Other (specify each purpose): _____

Description or nature of information to be used and/or disclosed:

- Records for the following dates: _____
- Physician dictation
- Laboratory Reports
- Radiology/X-Ray reports
- Emergency Department record
- Records for the following treatment: _____
- Billing statements for the following dates: _____
- Other: _____
- All Records

I authorize the information listed below to be used, disclosed, and/or received:

- Mental health/Development disability HIV / AIDS
 Drug and/or alcohol abuse diagnosis, prognosis, or treatment

Information to be released and how it will be used (describe how much and what kind): _____

The above information will not be released or disclosed unless specifically authorized.

EXPIRATION

This Authorization expires [insert date]: _____

NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization. Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this Authorization.

I may revoke this Authorization at any time. My revocation must be in writing, signed, and delivered to the following address: Privacy Officer, Barton HealthCare System, P.O. Box 9578, South Lake Tahoe, CA 96158. My revocation will be effective upon receipt, but will not be effective to the extent that Barton HealthCare System or others have acted in reliance upon this Authorization.

I may request a copy of this Authorization.

Information disclosed under this Authorization may be subject to re-disclosure by the recipient and might no longer be protected by federal or state confidentiality law. California law, however, prohibits the person receiving the patient's health information from further disclosing of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE

Date: _____ Time: _____ am/pm

Signature: _____
(patient/personal representative)

If signed by someone other than the patient, state your legal relationship to the patient and your grounds for authority: _____

Witness: _____

For Barton Purposes Only

Documentation provided: _____

