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

AUTHORIZATION

I hereby authorize ☐ MarinHealth Medical Center ☐ Other - Specify _____
to release my medical information, as described below, to:
Name: _____
Street Address: _____ City/State Zip: _____
Telephone: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

Name of Patient _____
Date(s) of Admission/Service _____ Date of Birth _____
Please check the appropriate box(es) below or describe your request under "Other".

☐ Discharge Summary ☐ Lab Results ☐ Emergency Room ☐ CD Films and Reports
☐ Operative / Pathology Reports ☐ X-ray Reports ☐ EKG Reports
☐ Other: _____

I specifically authorize release of the following information (check as appropriate):

☐ Mental health treatment information _____ (initial)
☐ HIV test results _____ (initial)
☐ Alcohol/drug treatment information _____ (initial)

A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.

PURPOSE OF THIS RELEASE

(check one or more)

☐ Inspection of Record ☐ Personal Copy ☐ Insurance ☐ Other _____

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires on: _____ (if no date is indicated, this Authorization will expire 12 months after the date of signing this form.)

ADDITIONAL RIGHTS (See reverse for more information)

I further understand that I have a right to receive a copy of this authorization upon my request.

AUTHORIZING SIGNATURE

_____ _____
Signature of Patient, Parent or Guardian Date of Signature

_____ _____
If signed by other than Patient, indicate relationship Witness

Print Name: _____
Legal Representative

marin health Medical Center
250 Bon Air Road
Greenbrae, CA 94904

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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 of the state of California.

Your Rights

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment eligibility for benefits.

- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, an delivered to this address:
  MarinHealth Medical Center
  HIM Department
  250 Bon Air Road
  Greenbrae, California 94904

- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.

- I may inspect and obtain a coy of the health information that I am authorizing for use or disclosure.

- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

California Law permits charging a fee for records. The copy charge is twenty-five cents ($.25) a page if copied from the original record. Pre-payment is necessary to receive any records. There is no charge if records are sent directly to your physician or to another health care facility.

MarinHealth and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.