AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

Section A: Patient Identification (Required) - Please Print Clearly

Patient Name:		Sex:	Date of Birth:			Medical Record Number (If known)
Address:	City			State	Zip	Phone #
If requested by Personal/Legal Representative (Name & Relationship):						

Section B: Request for Inspection and/or Copying of Your Health Information

You have the right to inspect and obtain a copy of your health information for as long as we maintain the information in our records, with certain limited exceptions. To submit a request, please complete Sections A - D.

Records will be mailed. ***Please make sure we have the correct mailing adddress.***

Under certain limited circumstances, we may deny your request to inspect and/or copy your health information. If access is denied, you may request that the denial be review. Instructions for the review process will be included with any denial. You also agree to pay any fees associated with copying and mailing the above records. Please contact the Health Information Department at (831) 755-0730 for applicable fees.

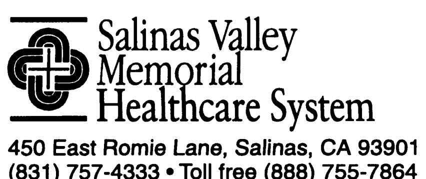
Section C: Authorization for Disclosure of Health Information (Complete only if the disclosure is to someone other than you or your Personal/Legal Representative)

I hereby authorize ☐ SVMH ☐ Clinics or ☐ Other (specify): ____________________
to release a copy of my health information to the person/organization specified below:

☐ Mail to:

Person/Agency/Organization:	Address:

1. I understand that I may refuse to sign this authorization and that Salinas Valley Memorial Hospital and Clinics may not condition my treatment upon whether I sign this authorization. I understand that if I have authorized the disclosure of information to someone who is not legally required to keep it confidential, the recipient may re-disclose it, and it may no longer be protected. I understand that I have a right to receive a copy of this authorization. Please contact the Health Information Management Department at (831) 755-0730 for applicable fees.



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2. I understand that this authorization is effective immediately and will remain in effect ______________________ (specify date, but no longer than six months from the date of this authorization). I reserve the right to withdraw or revoke information.

To withdraw or revoke this authorization, submit written request to the HIM Department.

- Address: 450 E. Romie Lane, Salinas, CA 93901
- Contact: (831) 755-0730 for more information and instructions

Section D:

Health Information to be accessed or disclosed (To be completed by all requestors)

1. Access and/or disclosure shall be limited to the following elements of my health information:

☐ All health information pertaining to my medical history, mental or physical condition and treatment received

OR

☐ Only the following records or types of health information (including any dates):

____

____

2. To access or disclose any of the following restricted information, initial the appropriate box(es):

_____HIV Test Result _____Genetics _____Fertility _____Alcohol/Drug Abuse

_____Psychiatric/Mental Health (additional approval required)

3. The purpose of the requested access or disclosure is:

☐ At the request of the patient

☐ Other: ____

Signature: ______________________________ Date: ____________________

If interpreted:

Interpreter Signature____________________ Print Name ____________________

Language______________________________ Date ___________ Time__________

Position/Relationship to Patient: ______________________________________