



AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Martin Luther King, Jr. Community Hospital and Medical Office will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.

PATIENT INFORMATION

Patient Name: _____ MRN: _____ FIN: _____
Date of Birth: _____ Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Email: _____

PURPOSE

This authorizes Martin Luther King, Jr. Community Hospital and Medical Office to disclose information as specified below for the following purposes: _____

RECIPIENT INFORMATION

Martin Luther King, Jr. Community Hospital and Medical Office may disclose this information to: ☐ Check if same as above (disclosure to patient)

Recipient Name: _____
Phone: _____ Email: _____ Fax Number: _____
Address: _____ City: _____ State: _____ Zip Code: _____

COPIES OF RECORDS OR MEDICAL RECORD INFORMATION

Within the Following Dates: _____ to _____

- | | | |
|---|--|---|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Consultation(s) | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Billing Records | <input type="checkbox"/> Radiology Reports/CD |

MEDIA	<input type="checkbox"/> Electronic	<input type="checkbox"/> Paper	DELIVERY PREFERENCE	<input type="checkbox"/> Email/ Secure Portal	<input type="checkbox"/> Mail	<input type="checkbox"/> Pick Up
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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: _____

The patient or personal representative → Signature _____
specifically authorize the release of health information relating to reproductive health services, including but not limited to abortion and abortion-related services, sexual health, reproductive health, contraception, gender affirming care, menstrual cycle, fertility, pregnancy, pregnancy outcome, plans to conceive and type of sexual activity with any individual or entity in another state.

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 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:
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