COMMUNITY MEDICAL CENTERS

DATE: ______________ MED. REC. # ____________________ ACCT# ________________

PATIENT INFORMATION

PATIENT NAME/AKA ____

TELEPHONE: __________ SOCIAL SECURITY # ______________ BIRTH DATE: __________

INFORMATION TO BE RELEASED FROM

I hereby authorize the release of all information in my medical record from

Name: Community Regional Medical Center

Address: 2530 E. Divisadero, Fresno, CA 93721

Including contents regarding drug/alcohol abuse, psychiatric, **psychotherapy notes and *HIV related (AIDS) diagnosis/test results. Exclusions: ____________________

INFORMATION TO BE RELEASED TO

Name of Organization / Person RECORDS DEPOSITION SERVICE, INC.

Address PO BOX 5054 City SOUTHFIELD State MI Zip 48086-5054

(*A separate authorization is required for each HIV disclosure and a **specific separate authorization requesting only psychotherapy notes is required.)

TYPE OF INFORMATION TO BE RELEASED

Dates of Treatment From____________ to ____________

TYPE OF RECORD

- ☐ All Medical Records (pertinent only) (*Limited to 2 years of information)
- ☐ History & Physical
- ☐ Consultation
- ☐ Operative Report
- ☐ Discharge Summary ____________________
- ☐ Other Information (specify) ____________________
- ☐ Psychotherapy notes only
- ☐ Radiology Report (specify) ____________
- ☐ Lab Results
- ☐ Evidentiary Examination
- ☐ ER Report

PURPOSE:

Purpose or need for this information is:

- ☐ Medical
- ☐ Legal
- ☐ Insurance
- ☐ Personal
- ☒ Other FOR DISCOVERY BEFORE TRIAL

FOR OFFICE USE ONLY

I.D. Checked ☐ Yes ☐ No Fee Explained ☐ Yes ☐ No

Amount Paid __________ Receipt # __________

☐ Mail ☐ Pick up Initials __________

Health Information Management

Authorization for Release of Protected Health Information

Continued on Back

ACCT# ______________

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Restrictions / Duration / Rights

- I authorize the release of the specified information from my medical records.
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality laws (HIPAA). However, under California law the requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law pursuant to state confidentiality laws.
- I revoke this authorization for Release of Protected Health Information as of ____________.
  Signature ______________________________
- This authorization may be revoked at any time. My revocation will be effective upon receipt, but ill have no impact on uses or disclosures made while my authorization was valid.
- CMC may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- This authorization expires six months after the date of signature, or as specified __________.
- A photocopy of this release is as effective as the original.
- I have received a copy of this authorization.
- ☐ If this box is checked, Community Medical Centers will receive compensation for the use or disclosure of my health information.

SIGNATURE: ______________________________ DATE: ______________

Patient / Legal Representative / Guardian

Authorized representative signing for the patient must also submit copies of the legal documents describing the personal representative's assignment of this authority.

If signed by other than patient, indicate relationship: ______________________________

Witness: (Signature / Print Name / Title / Initials) ______________________________

Interpreter Signature If Applicable

I have accurately and completely read the foregoing document to

____

Patient's / Legal Representative's Name

in ______________________________, the patient's or legal representative's primary language.

Language

(He/she) understood all of the terms and conditions and acknowledged (his/her) agreement thereto by signing the document in my presence.

Interpreter's Signature / Print Name / Title ______________________________ Date: __________