NORTHERN INYO HOSPITAL
Northern Inyo County Local Hospital District
150 Pioneer Lane · Bishop, California 93514 · Voice (760) 873-5811· Fax (760) 872-2768
Medical Records Voice (760) 873-2152 · Billing Office (760) 873-2190 · Fax (760) 873-6734

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Failure to provide all information requested may invalidate this authorization.

Patient Name: ____________________________________ Date of Birth: ______________________
Medical Record #: ________________________________ Social Security #: ___________________

I hereby authorize ____ to release to:
Name: ____ Telephone: _____________________
Address: ____ Fax: ________________________
☐ mail ☐ fax ☐ to be picked up by: _____________________ ☐ other, specify _________________

the following information:

☐ All health information pertaining to my medical history, mental or physical condition and treatment OR
☐ Only the following records or types of health information (include dates):

I specially authorize release of the following information (check as appropriate):
☐ Mental health treatment information ☐ HIV test results ☐ Alcohol/drug treatment information
A separate authorization is required to authorize disclosure or use of psychotherapy notes.

Purpose of requested use or disclosure: ☐ patient request; ☐ treatment; ☐ other (specify):
____

This authorization expires 30 days from date of signature or: ____________________________________

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
I may revoke this authorization at any time, but I must do so in writing and submit to the following address: Northern Inyo Hospital, 150 Pioneer Lane, Bishop, CA 93514. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization, if requested.
I have a right to receive a copy of this authorization. (☐ copy given by/date: ___________________**)**
Information disclosed pursuant to this authorization could be re-disclosed by the recipient.
Such disclosure is in some cases not protected by California law and may not longer be protected by federal confidentiality law (HIPAA).

____
Signature (patient / representative) Date

If signed by someone other than the patient, state your legal relationship to the patient:

____
Address: ____
Telephone: ___________________________ **Print** your name: _____________________________

____
Witness

A CHARGE MAY BE MADE FOR COPIES OF YOUR RECORDS, X-RAYS, OR PATHOLOGY SLIDES/BLOCKS

FOR HOSPITAL USE ONLY

Medical Record #___________________________

☐ Request completed	By:	Date:
☐ Request denied	By:	Date:
Describe records denied:		
UNREVIEWABLE GROUNDS FOR DENIAL:		
☐ Psychotherapy ☐ CLIA ☐ Civil, criminal, administrative proceeding ☐ Correctional institution exception ☐ Research exception ☐ Confidentiality of source exception		
REVIEWABLE GROUNDS FOR DENAIL:		
☐ Access requested is reasonably likely to endanger life or physical safety of the patient or another person		
☐ Access requested is reasonably likely to cause substantial harm to another person referenced in the requested information		
☐ Provision of access to representative is reasonably likely to cause substantial harm to the patient or another person		
☐ Denial sent	By:	Date:

Notes:

☐ Appeal received	By:	Date:
☐ Appeal request reviewed	By:	Date:
Appeal: ☐ Approved	Reviewed by:	Date:
☐ Request completed	By:	Date:
Appeal: ☐ Denied	Reviewed by:	Date:
Describe records denied:		
☐ Access requested is reasonably likely to endanger life or physical safety of the patient or another person		
☐ Access requested is reasonably likely to cause substantial harm to another person referenced in the requested information		
☐ Provision of access to representative is reasonably likely to cause substantial harm to the patient or another person		
☐ Appeal denial sent	By:	Date:

Notes: