AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.
Failure to provide all information requested may invalidate this authorization.

A. PATIENT INFORMATION:

Patient Name: ______________________________

Date of Birth: ____________ SS# (optional): ____________ Other names: ____________

B. ABOUT THE HEALTH INFORMATION:

I request and authorize COTTAGE HEALTH SYSTEM to release health information on the above named patient concerning the following treatment at SAINT FRANCIS MEDICAL CENTER:

1. Please **initial** to indicate the type of information to be disclosed:

____Medical ____* HIV ____** Chemical Dependency ____** Mental Health

* HIV Test results may only be sent directly to a physician.
**The Lanterman-Petris-Short ACT, and California Health and Safely Code require Cottage Hospital to obtain written permission from the Attending Physician for release of specific kinds of information.

2. Date(s) of visit or care (please be specific):______________________________
3. Reason(s) for visit or care (i.e., E.D., Inpatient, Outpatient, surgery etc.):______________
4. Specific health information to be released (refer to section H on reverse): ______________

____

5. List any restrictions or limitations (if any): ______________________________
6. I understand that this information will be used for the following purpose (i.e. follow-up with physician, attorney, insurance, personal files, etc):______________________________

C. TO WHOM INFORMATION SHOULD BE GIVEN:

Please choose one of the following:

1. I authorize that this information be ***sent to***: Name: ______________________________

Title / Position / Relationship to Patient: ______________ Fax: (____)__________
We fax to Dr.'s ONLY

____
(Street address) (City) (Zip) (Telephone)

2. I authorize this information to be ***picked up by:***

Name: ______________________ Title/Relationship ______________

Telephone: ______________________ (Cottage employee will call when copies are ready)

D. EXPIRATION

This authorization is effective now and will remain in effect until (insert date): ______________________

E. YOUR RIGHTS

You have a right to receive a copy of this Authorization. If you need to have a copy mailed to you, please provide your name and complete mailing address where you wish to have the copy sent:

_____ Please mail a copy to: Name: ______________________________

Address: ______________________________ State: ______________ Zip: ____________

Copy received: _____ Yes _____ No Copy Sent: _____ Yes _____ No Comment(s): ______________

You have a right to revoke (withdraw) this authorization at any time by submitting a signed written request to: Health Information Management, Santa Barbara Cottage Hospital (see address below). Your revocation will be effective upon receipt, but will not be effective to the extent that actions to comply with the original request have already been taken, or if the authorization was obtained as a condition of obtaining insurance coverage.

F. RESTRICTIONS

The recipient of Medical Information disclosed pursuant to this authorization may not further disclose Medical Information except in accordance with a new authorization or as specifically required or permitted by law.

G. COST & TIME

1. There is no charge for copies of health information sent directly to a health care provider.
2. Copies are transmitted within 15 days after a written request is received.
3. There is a clerical charge of $5.00 plus .25 cents per page for copies.
4. There is an additional $10.00 charge for copies being requested for same day pick up ***(service is subject to availability of personnel and completed reports).***

H. CONTENTS OF MEDICAL RECORD *(Please circle to request copies)*

Discharge Summary	Emergency Dept. Notes	Radiology Reports	Medications	OP Clinic ____________ (dates)
Physician's Orders	Typed Consults	CAT Scan Reports	Delivery Room Record	
Nurses Discharge Order	Operative Reports	MRI Reports	PKU Report	Other ____________
History & Physical	Anesthesia Notes	Laboratory Results	Fetal Monitor Strips	
Physician Progress Notes	EKG/EEG	Surgical Pathology	Blood Transfusions	Other ____________

I. SIGNATURE

Signature: ______________________________ Date: ______________

Print Name: ______________________________

If not signed by the patient, please indicate the relationship and furnish proof:

_______ Parent or guardian of minor patient (to the extent minor could not have consented to care)
_______ Guardian or conservator of an incompetent patient
_______ Beneficiary or personal representative of a deceased patient

Santa Barbara. Cottage Hospital, H.I.M. Dept., P.O. Box 689, Santa Barbara, CA 93102
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