EL CAMINO HOSPITAL
2500 GRANT ROAD, P.O. BOX 7025
MOUNTAIN VIEW, CA 94039-7025

Patient Name	
Medical Rec. #	LABEL
Physician	

Authorization to Release Protected Health Information

PATIENT'S NAME (print): _____ **DATE OF BIRTH**: _____

I, _____ phone: _____
(Patient or Legal Healthcare Representative)
hereby authorize use or release of the above named patient's health information as described below.

The following individual or organization is authorized to release the information:

_____

The information may be released to and used by the following individual or organization:

_____
(Name and Address)

INFORMATION TO BE RELEASED:

The information to be released is required for the following purpose:

___ Continued medical care ___ Legal Counsel
___ Insurance (for payment) ___ Worker's Compensation (for payment)
___ Other (specify): _____

The type of information to be released includes (please initial):

___ General medical/surgical care
___ Behavioral health care (including mental health or chemical dependency)
___ HIV test results

Please note if there are specific uses & limitations on use of the information by the recipient:

_____

Check only the desired records to be released. Dates of visit: _____

___ Pertinent information (includes history & physical, laboratory (excluding HIV) reports, x-rays, pathology reports, consultations, procedure reports, discharge summary)

___ History & physical exam	___ Laboratory reports	___ Doctors' orders
___ Consultations	___ Pathology reports	___ Progress notes
___ Procedure reports	___ EKG reports	___ Nurses' notes
___ Discharge summary	___ X-ray reports	___ Emergency records

___ Other (specify): _____

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Patient Name	
Medical Rec. #	LABEL
Physician	

Authorization to Release Protected Health Information

PATIENT'S NAME: _____

EXPIRATION OF AUTHORIZATION:

This authorization will expire upon completion of the specified disclosure, unless otherwise specified as follows: _____

Requestor's Initials: _____

NOTICE OF RIGHTS AND OTHER INFORMATION:

- I understand that authorizing release of this information is voluntary. If I refuse to sign this authorization, the requested information will not be released.
- Treatment, payment, enrollment, or eligibility for benefits will not be conditional upon this authorization being signed. However, if this authorization is needed for participation in a research study, I may be denied enrollment in the research study.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me (or a legal representative), and delivered to:
  El Camino Hospital - HIMS (ECHG23)
  2500 Grant Road
  Mountain View, CA 94040
- I understand that the revocation will not apply to information that has already been released based on this authorization.
- Information released based on this authorization could be re-released by the recipient and might no longer be protected by federal law. However, California law prohibits the person receiving health information from further release without authorization unless required or permitted by law.
- I may inspect or obtain a copy of the information for which I am authorizing release.
- I will be given a copy of this authorization form if I request it.

SIGNATURE:

Signature: _____ Date: _____

(Patient or Legal Healthcare Representative)

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

_____

Witness: _____

_____ Initial here if you have received a copy of this authorization.

HOSPITAL USE ONLY

Requested information [_] MAILED [_] FAXED [_] DELIVERED to: _____

Date: _____ Time: _____ am / pm By: _____