FRESNO SURGICAL HOSPITAL

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Date:_____

Patient Name:_____

Date of Birth:_____ SSN:_____

Information to be disclosed from:

Fresno Surgical Hospital
Health Information Management
6125 N. Fresno Street
Fresno, CA 93710
Telephone: (559) 447-7335 FAX: (559) 447-1095

Information to be used for the purpose of:

☐ Requested by patient ☐ Other:_____

I hereby request and authorize you to disclose information to:

Name:_____

Address:_____

_____

Disclosure Method:

☐ Pickup ☐ Mail ☐ FAX #_____ ☐ Other:_____

I authorize the use or disclosure of the above named individual's health information as described below.
Information to be disclosed:

☐ All records of treatment from_____ to _____

☐ Entire (Complete Record)

☐ Other:_____

☐ History & Physical Report	☐ Medication Record	☐ PACU Records
☐ Consultation Report	☐ Physician Orders	☐ IPS Notes
☐ Operative Report	☐ Progress Notes	☐ Alcohol / drug treatment information
☐ Discharge Summary	☐ Lab Results	☐ HIV Results
	☐ Radiology Reports	☐ Mental Health Information

- I understand that the information in my health record may include information relating to sexually transmitted disease, behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand there will be a charge for copying records.
- I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in the federal privacy regulations.
- Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____ If I fail to specify an expiration date, even or condition, this authorization will expire in six months.
- I understand that I may revoke this authorization in writing at any time by contacting Health Information Management at 559.447.7335
- I understand that this revocation does not apply to information that has already been disclosed in response to this authorization.
- Failure to sign this authorization
  - ☐ Will have no adverse impact on delivery of care or reimbursement of patient charges
  - ☐ Will have the following adverse impact:_____

Patient or Legal Representative Signature:

_____ Date:_____

Relationship to the patient:_____

Witness (if signed by legal representative):

_____ Date:_____

I revoke (cancel) this Authorization to Disclose Health Information previously signed on (date)_____

Cancellation Signature:_____

Date:_____

Office Use Only:

Name:_____

Date:_____

Disclosure Method: ☐ Fax ☐ Mail ☐ Pickup
