Madera Community Hospital 1250 E. Almond Avenue, Madera, Ca. 93637
559-675-5575 Fax: 559-675-5519

Authorization for Use or Disclosure of Protected Health Information

I, _____, hereby authorize my physician and/or administrative and
(Patient's printed name)
clinical staff to (check all that apply):

_____ use the following protected health information, and/ or

_____ disclose the following protected health information to;

Enter: _____
Name of Entity or persons to receive information — Address — Phone

Date(s) of service: _____ **Type of service:** _____
Level of Detail to be released: _____
Specific reports to be released: _____
Limitations: _____
****(Mental Health; Alcohol/Drug; HIV test results require written authorization of the patient.)****

This protected health information is being used or disclosed for the following purpose(s) and that purpose(s)only: _____

This authorization shall be in force and in effect until _____,
at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Health Information Management, Madera Hospital, 1250 E. Almond, Madera, Ca. 93637.

I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by Federal or State law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating health information for disclosure to a third party.

Patient's Signature	Date of Birth	Social Security Number
Patient's Address	Phone	Today's Date
Signature of Guardian or Representative (*State relationship to patient*)		Today's Date
Signature of Witness		Today's Date

_____Please supply me with a copy of this release form.

PHOTOCOPY IS AS VALID AS THE ORIGINAL