Completing this document authorizes NorthBay Healthcare to disclose and use your health information consistent with California and Federal law (HIPAA) concerning the privacy of such information. This authorization remains a part of your medical record. Please allow 15 calendar days to complete the processing of this authorization.

PATIENT IDENTIFICATION – PRINT

Name: (last) ____________ (first) ____________ (middle) ________

Address: ____________ State: ______ Zip Code: ________

City: ____________ Date of birth: ________

Contact phone number: ____________

USE AND DISCLOSURE OF HEALTH INFORMATION

I would like to (check):

- ☐ Obtain copies of my medical record. Requests for personal use will be charged at a rate of $.25 per page. ($.50 per page for microfilmed records)
- ☐ Request a copy of my medical record be sent to persons/organizations authorized to receive this information.
- ☐ Request for medical records from another provider sent to NorthBay Healthcare.

PURPOSE OF REQUEST

- ☐ At the request of the patient
- ☐ Other ____________

COVERING THE PERIODS OF HEALTH CARE (DATES OF TREATMENTS)

From (date): ____________ To (date): ____________

TYPE OF INFORMATION TO BE RELEASED

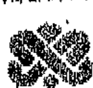
- ☐ Clinic Notes
- ☐ History & Physical(s)
- ☐ Discharge Summary(ies)
- ☐ Operative Reports
- ☐ Pathology Report(s)
- ☐ Consultation(s)
- ☐ Radiology Report(s)
- ☐ EKG(s)
- ☐ Laboratory Report(s)
- ☐ Records from external care providers
- ☐ Complete medical record
- ☐ Other ____________

HIGHLY CONFIDENTIAL INFORMATION – INITIAL TO SPECIFICALLY AUTHORIZE THE USE AND/OR DISCLOSURE OF THE INFORMATION

- ☐ ____ Mental health treatment information or developmental disability
- ☐ ____ HIV / AIDS test results or treatment information

EXPIRATION

This authorization expires (insert date or event) ____________ or 180 days from date of signature on this authorization or until NorthBay Healthcare fulfills this request, whichever occurs first.



NORTHBAY™ HEALTHCARE 1200 B. Gale Wilson Blvd., Fairfield, CA 94533

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

HIPAA/Correspondence

WHITE: CHART YELLOW: PATIENT

45 0349 (7/07)

I HEREBY AUTHORIZE THE FOLLOWING HEALTHCARE PROVIDER

Name: ____________________

Address: ____________________

City: ____________ State: ______ Zip Code: ______

TO FURNISH MY HEALTH INFORMATION TO

Name: ____________________

Address: ____________________

City: ____________ State: ______ Zip Code: ______

MY RIGHTS

- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the address checked above. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving your health information from making further disclosure of it unless authorization for such disclosure is obtained from you or unless such disclosure is specifically required or permitted by law.
- I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits.
- I can inspect or receive copies of the protected health information to be used or disclosed.

SIGNATURE

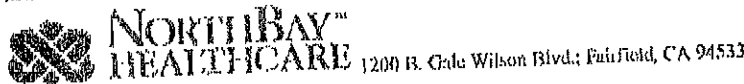
I authorize NorthBay Healthcare to use and disclose my protected health information as specified by this request.

Date: ____________ Time: ____________ am / pm

Signature: ____________________
(patient or patient representative)

Authority to sign if not patient: ____________________
If signed by someone other than the patient, please provide documentation appointing guardianship/conservatorship authorizing signature for release of information.

For NBHC's internal use only: Identity of requestor verified ______



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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION