

REQUEST FOR RELEASE OF MEDICAL RECORD INFORMATION

I REQUEST AND AUTHORIZE O'CONNOR HOSPITAL, 2105 FOREST AV., SAN JOSE, CA 95128, TO RELEASE INFORMATION FROM MY MEDICAL RECORD TO:

Name of MD, Ins. Co., etc: _____

Address _____

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Telephone: _____

Information To Be Released:

Treatment dates: _____

Please check type of information to be released:

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Emergency Room record
<input type="checkbox"/> History and physical exam	<input type="checkbox"/> Progress notes
<input type="checkbox"/> Laboratory test results	<input type="checkbox"/> X-ray films / images
<input type="checkbox"/> Diagnosis & treatment codes	<input type="checkbox"/> Itemized bill
<input type="checkbox"/> Consultation reports	<input type="checkbox"/> X-ray reports
<input type="checkbox"/> Operative reports	<input type="checkbox"/> Complete health record (every page)
<input type="checkbox"/> EKG/ Echo	<input type="checkbox"/> Psychiatric/drug/alcohol treatment **

** See next page for additional verification of release request

Other, (specify) _____

Purpose of Request

<input type="checkbox"/> Treatment or consultation	<input type="checkbox"/> At the request of the patient. There may be a charge for this service. \$.25/page plus tax	<input type="checkbox"/> Billing or claims payment
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Other, (specify) _____

See next page

REQUEST FOR RELEASE OF MEDICAL RECORD INFORMATION (continued)

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Correspondence Staff, Medical Records Dept . Unless revoked, this authorization will expire on the following date or event _____, or one year from date of signature, unless otherwise specified.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Check One:** Yes No

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. **Check One:** Yes No

Signature of Patient or Personal Representative Who May Request Disclosure

I can inspect or copy the protected health information to be used or disclosed. I authorize **O'Connor Hospital** to use and disclose the protected health information specified above.

Signature: _____ Date: _____

Authority to Sign if not patient: _____ Relation to patient: _____

Identity of Requestor Verified via: Photo ID Matching Signature
 Other, specify _____ Verified: by: _____