San Joaquin General Hospital */ A division of San Joaquin County Health Care Services*

DATE:4-16-10

TO: UNISOURCE

We are returning your recent request for records because the authorization you submitted does not comply with the recent HIPAA requirements.

Please resubmit a corrected authorization, making sure all of the following are included in it. We will process your request upon receipt of a proper authorization.

To be valid, your authorization must include:

*The authorization must be addressed to San Joaquin General Hospital.

* The authorization must be signed and dated by the person authorizing the release.

* The authorization must have an expiration date.

* A description of the information to be released.

* If the authorization is signed by a representative of the patient, a description of the representatives authority must be provided.

* The authorization must include the specific identification of the person(s) or class of persons to whom the disclosure may be made.

* A statement that the information being disclosed may be redisclosed and no longer is protected by HIPAA.

* A statement that the patient has the right to revoke this authorization in writing and either the exceptions to the right to revoke and a description of how to make a revocation or a reference to the entity's notice of privacy practices required by the privacy regulations.

Post Office Box 1020 Stockton California 95201 / 209 468 6640

San Joaquin General Hospital
500 W. Hospital Rd.
Stockton, CA 95203
(209) 468-6000

AUTHORIZATION for RELEASE of INFORMATION

I, ____, hereby authorize
Patient or Legal Representative

San Joaquin General Hospital and Clinics to use or disclose my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal policy regulations.

Patient Name: ______________________ Med Rec/ID Number: __________

Date of Birth: ____________ Sex: ______ SSN: ____________________

Persons/organization providing the information: Persons/organization receiving the information:

(From) (To)

SAN JOAQUIN GENERAL HOSPITAL
ATTN: MEDICAL RECORDS
P.O. BOX 1020
STOCKTON, CA 95201
PH: (209) 468-6646
FAX: (209) 468-6653

Specific Medical Condition(s): ______________________________
And/or
Specific Timeframe(s): ______________________________

What is the purpose of the disclosure? ______________________________

(**Note:** "at the request of the individual" is a sufficient description of the purpose when the patient initiates the authorization and elects not to provide a statement of purpose.)

A. Type of Records Needed:

- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Laboratory Test(s)
- ☐ Consultation Report(s)
- ☐ Outpatient Clinic Notes
- ☐ Operative Reports
- ☐ Prenatal/Delivery Record
- ☐ Complete Medical Record
- ☐ History and Physical
- ☐ Emergency Record
- ☐ Pathology Report(s)
- ☐ Radiology Test(s)
- ☐ Other ______________________________

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AUTHORIZATION for RELEASE of INFORMATION

B. I specifically authorize release of the following information (check if appropriate):

- ☐ Alcohol/Drug Treatment Records
- ☐ HIV test results

NOTE: A separate authorization is required to authorize the disclosure of psychotherapy notes.

☐ All of the records marked above pertaining to me.
☐ Only the records from __________ Date(s) of Treatment

Exceptions: ____

I understand that this authorization shall become effective immediately and shall remain in effect until ____________ (six months from date of signature).

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I understand that I may revoke this authorization at any time by completing the Revocation of Authorization Form, obtained from the Medical Records/HIM Department. The revocation will only be effective from the date it is received in this office and will not apply retroactively.

I further understand that I have the right to refuse to sign this form and that my refusal will not result in SJGH conditioning the provision of health care with two exceptions:

1. If it is for disclosure of information created for research that includes treatment.
2. If it is for disclosure of information created for the sole purpose of disclosure to a third party.

I also agree to pay any fees associated with copying, reviewing and mailing the requested records. I understand that I am entitled to receive a copy of this authorization.

I have a right to receive a copy of this authorization. If this box is checked, ☐ the Requestor will receive compensation for the use or disclosure of my information.

Print Name: ____

Signature: ____

Date: ______________________________ Time: __________ am/pm

If signed by other than patient, indicate relationship: ____________________

Witness: ____