FAIRCHILD MEDICAL CENTER

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Please send request to:
Fairchild Medical Center
Health Information
444 Bruce Street, Yreka, CA 96097
Phone: (530) 841-6237 Fax: (530) 842-0233

Release of Information Hours:
M-F 8:00 a.m. – 4:00 p.m.

This authorization is for the use or disclosure of health information pertaining to:

Patient's Name: Last: _____ *First* _____ *MI* _____

DOB: _____ *Phone Number:* _____ *Medical Record #* _____

I hereby authorize:

- ☐ Fairchild Medical Center, 444 Bruce Street, Yreka, CA 96097
- ☐ (Other Healthcare Provider) _____
  Name and address

To release health information to:

_____ _____
(Name of Person or Organization Receiving Information) *Mailing Address City State Zip Code*

Method of Release:

- ☐ Mail records/film/CD to the address above by regular mail
- ☐ Pick up at the hospital
- ☐ I will visit the hospital to inspect the records

Under certain circumstances, FMC may deny your request to inspect and/or copy your health information. If access is denied, you may request that the denial be reviewed. Instructions for the review process will be included with any denial.

PATIENT LABEL

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This authorization applies to the following information:

- ☐ Medical Records *(Specify types of records and date(s) of service)*:_____
  _____
  _____
- ☐ Radiology Film/CD *(Please request from Imaging Department)*
- ☐ Billing Records
- ☐ Other Health Information *(Specify)*:
  _____

A specific authorization is required to disclose information regarding the following:
(Check box and sign to specify information to be disclosed)
Signature

- ☐ Psychiatric/Mental Health _____
- ☐ Drug/Alcohol Abuse _____
- ☐ HIV Lab Test Result _____

PURPOSE: The recipient may use the health information authorized on this form solely for the following purpose (Specify):

_____
_____

- ☐ Allowing PHI to be shared within the Multi-Disciplinary Team (MDT), as described under WIC18999.8, for the purposes of coordinating services. All MDT members will hold this information confidential, as allowed by law, and will use the information for their agency coordination and benefit of the patient.

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EXPIRATION: This Authorization becomes effective immediately and shall expire on [date]: _____. (Not to exceed 30 days from the request date.)

MY RIGHTS

- I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.
- The recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless the use or disclosure is specifically permitted by law. If further use or re-disclosure by the recipient is permissible, the information may no longer be protected by the federal privacy law (HIPAA).
- I reserve the right to withdraw or revoke this authorization, in writing, at any time, except to the extent that FMC has already disclosed the information. I must submit my revocation to FMC Health Information Department, 444 Bruce Street, Yreka, CA 96097.
- I have a right to receive a copy of this authorization upon my request.
  Copy requested and received: ☐ Yes ☐ No Initial _____

Signature: _____ **Date:** _____

Name of individual if signed by someone other than the patient: _____
(Print)

If signed by other than patient, indicate legal relationship: _____

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For Health Information Personnel Only

Method of Release:

- ☐ In person (Have patient acknowledge receipt by initialing here _____)
- ☐ Fax (Number _____)
- ☐ Mail (Address sent to_____)

Information copied/released to requestor: _____

Signature/Date of person releasing information: _____

Notes:

_____

_____

PATIENT LABEL