



San Joaquin General Hospital
 PO. Box 1020
 Stockton, CA 95201-1020
 (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 privacy regulations.

Patient Name: _____ Med Rec/ID Number: _____ Date of Birth: _____ Sex: _____ Date(s) of Service: _____

Persons/organization providing the information: (From) _____ (To) _____

_____	_____
_____	_____
_____	_____

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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Outpatient Clinic Notes | <input type="checkbox"/> History and Physical |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Emergency Record |
| <input type="checkbox"/> Laboratory Test(s) | <input type="checkbox"/> Prenatal/Delivery Record | <input type="checkbox"/> Pathology Report(s) |
| <input type="checkbox"/> Consultation Report(s) | <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Radiology Test(s) |
| <input type="checkbox"/> Other _____ | | |



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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 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 the 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: _____