

### AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

#### Explanation

This authorization for use or disclosure of my health information is required by state and federal law. Failure to provide all information requested may invalidate this authorization.

### Authorization

I hereby authorize the use or disclosure of my health information as follows:
Summit Campus

Address	Street	City	State	Zip	Phone
	ed to receive my info	mation			

history, mental, chemical dependency, or physical condition and treatment received. Provide only the following records or types of records (provide treatment dates):

All of my records from (enter dates) (Note: HIV test results require a special authorization)

The recipient may use my health information only for the following purposes: (not required when patient is the recipient)

#### Expiration

This authorization expires (enter date)

## Restrictions

California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

# **Your Rights**

• I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.

60070 (4/03)

• I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address:

For the Ashby/Herrick Campus.

For the Summit Campus: Summit Medical Center Health Information Services/ROI Unit 350 Hawthorne St. Oakland, CA 94609

• My revocation will be effective upon receipt, but will have no- impact on uses or disclosures made while my authorization was valid.

• I have a right to receive a copy of this authorization.

If this box is checked, copy was requested and received. Initials\_\_\_\_\_

- I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.
- If this box is checked, ABSMC will receive compensation for the use or disclosure of my health information.

Patient Name (print name)	Date of Birth
Other names used:	
Your Signature	Date
Patient/Personal Representative Signature	
Relationship to Patient:	
Witness	

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