3ROI

Please read the information on the reverse side before completing this authorization

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

Name and address of persons/organizations authorized to disclose the information:

☐ John Muir Health Walnut Creek
1601 Ygnacio Valley Road, Walnut Creek CA 94598

☐ John Muir Health Concord
2540 East Street, Concord CA 94520

☐ Other _____

_____

1. I authorize the following persons/organizations to receive my health information (include address):

_____

_____

2. This authorization applies to:

☐ Only the following records or type of health information or specific dates of treatment.

_____

_____

☐ All health information pertaining to any medical history, mental or physical condition and treatment received. Includes information related to drug, alcohol and/or psychiatric conditions or conditions pertaining to sexually transmitted diseases, including AIDS. HIV test result information will NOT be released unless specifically requested.

List specific dates of treatment needed for use/disclosure: _____

Exclusions: _____

3. The receiver may use the medical information for the following purposes only:

_____

California law prohibits the receiver from making further disclosure of my health information unless the receiver obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

4. This authorization expires: (date)_____. If blank, authorization will expire 1 year from date of signature.

Signature: ☐ Patient ☐ Legal Representative ☐ Spouse ☐ Financially Responsible Party

DATE	TIME	SIGNATURE	DAYTIME PHONE

RELS-36 (1/6/11)

JOHN MUIR HEALTH

AUTHORIZATION FOR USE/ DISCLOSURE OF PHI

WHITE - CHART YELLOW - PATIENT

PATIENT LABEL

Print Name:

DOB:

MR#:

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the use and/or disclosure of individually identifiable health information, as set forth below, consistent with California and Federal laws concerning the privacy of such information. **Failure to provide ALL information requested may invalidate this authorization.**

YOUR RIGHTS

- I may refuse to sign this authorization, which invalidates this authorization.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the John Muir Health entity to which I originally submitted the authorization.
- My revocation will be effective upon receipt, but will not be effective to information disclosed prior to the date of revocation.
- I have a right to receive a copy of this authorization.
- John Muir Health may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization, except:
    - for research related treatment.
    - when the authorization is for eligibility/enrollment/underwriting/risk rating determination.
    - when the sole purpose for creating the requested protected health information is to disclose to a third party.

Please turn this form over to complete the authorization.

PATIENT LABEL

Print Name:

DOB:

MR#: