



Sequoia Hospital

CHW

170 Alameda de las Pulgas, Redwood City, CA 94062-2799
(650) 369-5811

GENERAL AUTHORIZATION

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AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Note: Do Not Use This Form If Records To Be Released Relate to **HIV Test Results.**)

EXPLANATION: This authorization is necessary for us to comply with state and federal laws pertaining to the use or disclosure protected health information ("PHI") about the patient identified below. Please provide all requested information. Failure to provide all requested information may prevent Sequoia Hospital from acting on this Authorization.

Name of Patient _____ Date of Birth _____

Other Names _____ M.R. or Account # _____

1. **PERSONS AUTHORIZED TO DISCLOSE PHI.** I authorize the following person(s) or class of persons to disclose the health information described in Section 2 below: *(State name of physician or specific identification of person or class of persons)* Release of Information personnel

2. **DESCRIPTION OF INFORMATION.** This Authorization permits the use and/or disclosure of the following information about patient: *(Check all applicable boxes and initial selection as required.)*

_____ (Initial) All health information.

Or, only the following records or types of health information and/or only on the specified date(s).

Date(s) of Treatment: _____ Type of Treatment: _____
(Inpatient, Emergency Dept., Outpatient, Other)

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Billing records | <input type="checkbox"/> EKG Results | <input type="checkbox"/> Medications | <input type="checkbox"/> Operative Report | <input type="checkbox"/> X-Ray Results |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Nurse's Notes | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Emergency |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Orders | <input type="checkbox"/> Progress Notes | Room Records |

All health information relating to above date(s) or type of treatment

_____ (Initial) **Others** _____

I understand that the information to be released may also include any medical history, physical or mental condition, services rendered or treatment received.

3. **AUTHORIZED USERS AND RECIPIENTS.** I hereby authorize the following person or class of persons to receive and/or use the health information described in Section 2 above: *[State name, title (if applicable)]*.

Name: _____

Address: _____ City/State/Zip _____

4. **PURPOSE.** I hereby authorize the information checked in Section 2 above to be used and/or disclosed for the following purposes: *(Check all applicable boxes):*

Requested by patient or personal representative.

Others: _____

5. **RIGHT OF REVOCATION.** I understand that I have the right to revoke this authorization at any time, provided that my revocation is in writing and conforms to requirements described in Sequoia Hospital's Notice of Privacy Practices, which is available online at www.chw.edu/privacy, or in person at Sequoia Hospital.



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- 6. **LIMITS TO REVOCATION.** I understand that my revocation will be effective upon its receipt by the person(s) I authorized in Section 1 but would not be effective to the extent that such persons have acted in accordance with this Authorization and in reliance thereon. With respect to the person(s) I authorized to receive and use health information described in Section 3, if patient (or personal representative) requested this Authorization, any revocation will be effective only when I communicate my revocation directly to them.
- 7. **REDISCLASURE.** I understand that if the recipient of my information in Section 3 above is not a healthcare provider, a health plan or health care clearing house or not an entity required to comply with federal or state health privacy regulations, my health information may be further disclosed by such recipient and my information may no longer be protected by state and federal laws. If this Authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the substance abuse information under federal substance abuse confidentiality requirements.
- 8. **CALIFORNIA / ARIZONA RESTRICTION.** I understand that a recipient of medical information in California or Arizona may not further disclose medical information about me (patient) unless a new Authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.
- 9. **RIGHT TO REFUSE TO SIGN.** I understand that I do not have to sign this authorization and that my failure to sign this authorization will not affect my ability to obtain treatment, payment or benefits.
- 10. **AUTOMATIC ONE-YEAR DURATION.** This authorization will automatically expire after one (1) year from date of execution unless a different end date or event is specified below.

End Date: _____ or Event Name: _____

11. **COPY RECEIVED.** I acknowledge receipt of a signed copy of this authorization. _____ (initial)

Signature of patient (or personal representative, if applicable)

Date

Print name of personal representative (if applicable)
(Legal representative, parent, guardian, spouse, financially responsible party)

Relationship to patient (If signatory is anyone other than patient, describe signatory's relationship to patient.)

Address

Witness (optional)

Phone No.

Type of ID presented. Attach copy. (optional)

Patient/Representative Identification Verified: *Initials* _____ *Department* _____

ATTENTION RECIPIENT: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF DISCLOSURE