Dignity Health Medical Foundation
Woodland Clinic Medical Group

Release of Information Department
1207 Fairchild Court
Woodland, CA 95695-4398
Tel. (530) 668-2640
Fax (530) 662-7438

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient: _____ Date of Birth: _____

Other Names: _____ Telephone Number: _____

Address: _____ City/State/Zip: _____

Medical Record or Account #: _____
(Clinic use only)

I AUTHORIZE:

DHMF - Woodland Clinic Medical Group

TO DISCLOSE TO: Hoosier Services Inc.
(persons/organizations authorized to ***receive*** the information)

at the following address: 18032 Lemon Drive, #C-618, Yorba Linda, CA 92886
(complete street address, city, state and zip code)
Phone:800.882.4156; Fax: 800.882.4957; Email:service@hoosierservicesinc.com

☐ **THE FOLLOWING RECORDS,** specific types of health information, or records for the date(s) of treatment as specified:

DATE(S) OF SERVICE: _____

☐ Clinic Notes
☐ Laboratory Reports
☐ Radiology Reports
☐ Other: _____

☐ **THE FOLLOWING INFORMATION contained in the records specified below (initial applicable lines and boxes below):** ***A separate authorization is required for the use or disclosure of psychotherapy notes or research health information.***

____ Mental health or developmental disability treatment records (excludes "psychotherapy notes")

____ Substance abuse treatment records

____ HIV test results (This authorizes disclosure of laboratory test results only. *Note that your records may include information concerning your HIV status <u>even</u> if you do not check this box.)*

☐ **ALL RECORDS** regarding my treatment, hospitalization, and outpatient care. Please note that DHMF releases **<u>the most recent two years</u>** to satisfy an ALL RECORDS request **<u>unless</u>** additional dates below are specified:

☐ Additional ***Date(s) of Service***: _____

PURPOSE: The purpose and limitations (if any) of the requested use or disclosure is:

☐ At the request of the patient or personal representative; ***OR***

☐ Oral disclosure of my protected health information to personal representative/ family/friend/caregiver (whichever one applies) who participates in my care; ***OR***

☒ Other: Life Insurance

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution ***unless a different end date*** is specified: _____.
(date of expiration)

MY RIGHTS:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: ***DHMF - Woodland Clinic, Release of Information Dept., 1207 Fairchild Court, Woodland, CA 95695.*** My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have the right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

SIGNATURE: _____ Date: _____
(Patient or personal representative)

_____ _____
Print name of personal representative Relationship to patient

Patient/Representative Identification Verified. *Initials:* _____ *Dept:* _____

⇨ PICTURED I.D. MUST BE PRESENTED ⇦