3ROI

I. **Use or Disclosure:** I hereby authorize *(select appropriate JMH entity or location below)*:
- ☐ John Muir Health Walnut Creek, 1601 Ygnacio Valley Road, Walnut Creek CA 94598
- ☐ John Muir Health Concord, 2540 East Street, Concord, CA 94520
- ☐ John Muir Physician Network Practice Office (specify practice location below):

_____

- ☐ John Muir Health Behavioral Health Center, 2740 Grant Street, Concord, CA 94520
- ☐ Other (specify): _____

II. To disclose or release my health information to the following person/organization below:

Persons/Organizations authorized to receive the information:

Hoosier Services Inc.

Address - street, city, state, zip code:

18032 Lemon Dr.,#C-618, Yorba Linda, CA 92886

Additional Receiving Parties (Behavioral Health Center Requests Only):
Psychiatrist: _____ Therapist: _____ PCP: _____ Other: _____

III. **Preferred method of delivery:** ☐ Mail ☐ Patient will pick up ☐ Family member will pick up
Name: _____ Phone: _____

IV. **This authorization applies to the following health information:**

a. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received, OR

☐ Only the following records or types of health information (including dates):

_____

b. I specifically authorize the release of the following information (check as appropriate):

☐ **Mental health treatment information** ☐ **HIV test results** ☐ **Alcohol/drug treatment information**

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

V. **Purpose of use or disclosure:** ☐ Patient request; ☐ Further Medical Care ☐ Insurance **OR**
☐ Other: _____

VI. **Expiration:** This authorization expires on (date): _____. If blank, authorization will expire in 1 year from date of signature.

Signature: _____ **Date:** _____ **Time:** _____ **Phone:** _____

Print Patient Name: _____ **Date of Birth:** _____

Print Requestor Name (if other than patient): _____

Relationship to Patient: ☐ Legal Representative ☐ Spouse ☐ Financial Responsible Party

RELS-36 (2/4/14)

JOHN MUIR HEALTH

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

WHITE - CHART YELLOW - PATIENT

PATIENT LABEL

Print Name:

DOB:

MR#:

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. Please mail completed form to the appropriate John Muir Health entity where treatment or services were rendered. To inquire about the status of your request, please call the phone number of the appropriate entity Health Information Management department listed below.

Location of Treatment/Services	Where to Submit Request
John Muir Health, Concord Campus	Health Information Management 1400 Treat Blvd, Walnut Creek CA 94597 (925) 674-2322 FAX: (925) 674-2317
John Muir Health, Walnut Creek Campus	Health Information Management 1400 Treat Blvd, Walnut Creek CA 94597 (925) 947-5375 FAX: (925) 947-3235
John Muir Physician Network Practices	Health Information Management 1400 Treat Blvd, Walnut Creek CA 94597 (925) 941-2660 FAX: (925) 947-3235
John Muir Health, Behavioral Health Center	Health Information Management 2740 Grant Street, Concord, CA 94520 (925) 674-4105 FAX: (925) 686-6783

Notice of Rights and Other Information

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits, except in the following circumstances:
  - When the authorization is for eligibility, enrollment, underwriting or risk rating determination.
  - When the sole purpose for creating the requested protected health information is to disclose to a third party.
  - For research related treatment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or an authorized legal representative, and delivered to the appropriate John Muir Health entity and location where the original authorization request was submitted (see above). My revocation will take effect upon receipt, except to the extent those others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure in some cases is not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is permitted or required by law.

PATIENT LABEL

Print Name:

DOB:

MR#: