San Joaquin General Hospital
500 W. Hospital Rd.
French Camp, CA 95231
(209) 468-6650 Fax: (209) 468-6653

AUTHORIZATION for RELEASE of INFORMATION

I, _____, hereby authorize
Patient or Legal Representative

San Joaquin General Hospital and Clinics to use or disclose my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy act.

Patient Name: _____ Med Rec/ID Number: _____

Date of Birth: _____ Sex: _____ Date(s) of Service: _____

Persons/organization providing the information:
(From)
SAN JOAQUIN GENERAL HOSPITAL
ATTN: MEDICAL RECORDS
500 W. HOSPITAL ROAD
FRENCH CAMP, CA 95231
PHONE (209) 468-6646
FAX (209) 468-6653

Persons/organization receiving the information:
(To)
Hoosier Services Inc.

18032 Lemon Dr.,#C-618,
Yorba Linda,CA92886
Phone:800.882.4156;Fax:800.882.4957

Specific Medical Condition(s): _____
And/or
Specific Timeframe(s): _____

What is the purpose of the disclosure? Insurance Purpose

(**Note:** "at the request of the individual" is a sufficient description of the purpose when the patient initiates the authorization and elects not to provide a statement of purpose.)

A. Type of Records Needed:

☒ Discharge Summary	☒ Outpatient Clinic Notes	☒ History & Physical
☒ Progress Notes	☒ Operative Reports	☒ Emergency Record
☒ Laboratory Test(s)	☐ Prenatal/Delivery Record	☒ Pathology Report(s)
☐ Consultation Report(s)	☒ Complete Medical Record	☒ Radiology Test(s)

☒ Other All med records from _____

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B. I specifically authorized release of the following information (check if appropriate):
- ☐ Alcohol/Drug Treatment Records
- ☐ HIV test results

NOTE: A separate authorization is required to authorize the disclosure of psychotherapy notes.

☐ All of the records marked above pertaining to me.
☒ Only the records from _____ Date(s) of Treatment.

Exceptions: _____

I understand that this authorization shall become effective immediately and shall remain in effect until _____ (six months from date of signature).

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I understand that I may revoke this authorization at any time be completing the Revocation of Authorization Form, obtained from the Medical Records/HIM Department. The revocation will only be effective from the date it is received in this office and will not apply retroactively.

I further understand I have the right to refuse to sign this form and that my refusal will not result in SJGH conditioning the provision of health care with two exceptions:

1. If it is for disclosure of information created for research that includes treatment.

2. If it is for disclosure of information created for the sole purpose of disclosure to a third party.

I also agree to pay any fees associated with copying, reviewing and mailing the requested records. I have a right to receive a copy of this authorization. If this box is checked, ☐ the requester will receive compensation for the use or disclosure on my information.

Print Name: _____

Signature: _____

Date: _____ Time: _____ am/pm

If signed by other than the patient, indicate relationship: _____

Witness: _____