San Mateo Medical Center
A County System of Healthcare

Authorization for Release of Patient Information

I hereby authorize

Disclosing party: San Mateo Medical Center
Address: 222 WEST 39TH AVENUE
City/State/Zip: SAN MATEO, CA 94403

To disclose to

Name of recipient: Hoosier Services Inc.
Address: 18032 Lemon Drive, suite C-618
City/State/Zip: Yorba Linda, CA 92886
Phone/Fax: Ph:800.882.4156 / fax:800.882.4957

Medical records/information pertaining to

Patient name _____ MR No. _____
Date of birth _____ Phone No. _____
Address _____

Medical records/information to be disclosed

X Medical X Mental Health X Drug/Alcohol X HIV blood test

Other (include dates) _____

Purpose of disclosure

□ At the request of the patient
□ Other _____

Revocation: This authorization is subject to written revocation at any time. The revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon it. **Re-disclosure**: I understand that the recipient may not lawfully further use or disclose this information unless another authorization is obtained or unless such use or disclosure is specifically required or permitted by law. **Voluntary authorization**: Authorization to release health information is voluntary. Treatment, payment, or operations will not be conditioned on signing an authorization. **Copy**: You are entitled to receive a copy of this authorization. Please see your *Notice of Privacy Practices* for a complete list of your rights. **Duration**: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here: _____.

Signature_____ Date_____

Relationship (if other than patient) _____