SANTA CLARA VALLEY MEDICAL CENTER

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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PATIENT INFORMATION:

Medical Record #: _____

Patient Name: Last: _____ First: _____ MI: _____

Birth date: ____/____/_____ Telephone: ( ) _____ Email: _____

LOCATION OF MEDICAL RECORDS: (Check all that apply)

Valley Medical Center	Valley Health Center Clinics:	
☐ Valley Medical Center Hospital	☐ East Valley	☒ Milpitas
☐ Valley Medical Center Specialty Clinics	☐ Gilroy	☐ Sunnyvale
☐ Employee Health	☐ Lenzen	☐ Tully
	☐ Moorpark	☐ Bascom

Other organization that will release records (not listed above)

Name:

Mailing Address: City: State: Zip: Phone:

RELEASE MEDICAL RECORDS TO:

☒ **Person or Organization** ☐ **Valley Health Center**

Name: Hoosier Services Inc.

Mailing Address: 18032 Lemon Dr.,#C-618 City: Yorba Linda State: CA Zip: 92886 Phone: 800.882.4156

REQUESTED FORMAT: (Check one)

☐ Paper	☐ CD (if available)	☐ Review records
☐ Mail records	☐ Pick up records. (Location name):	

AUTHORIZATION TO RELEASE: Check the appropriate boxes, provide specific information as needed.

☐ **Medical Records** (see reverse for common documents in a medical record)

☐ **All Medical Records**	☐ **Dental Records**	☐ **Imaging/Imaging Results**

Specific Medical Records: List Document name or date of service:

SPECIFIC RECORD AUTHORIZATION FOR RELEASE: Check appropriate boxes. Sign and date.

☐ Genetic Testing Info	Signature:	Date:
☐ HIV Blood Test Info	Signature:	Date:
☐ Drug/Alcohol Treatment	Signature:	Date:
☐ Mental Health Treatment	Signature:	Date:

LIMITATIONS: Indicate below any limitation to the records requested (dates, treatments)

☒ **No Limitations**

SANTA CLARA VALLEY MEDICAL CENTER

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

MRN #: _____

Pt Name: _____

_____

PURPOSE: The person who receives the health information can use it only for the following reason

EXPIRATION This authorization is valid immediately and will be valid until _____ *(date)*.
If I do not write in a date, it will expire (6) six months from the date it was signed.

MY RIGHTS

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment, payment, or eligibility of benefits. I may inspect or obtain a copy of the health information that I am being asked to disclose.

The information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

COPY: I understand that I have a right to receive a copy of this authorization

CANCELLATION: I may revoke this authorization at any time, but I must do so in writing and submit to the address listed below. My cancellation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
Submit your cancelation request to: Santa Clara Valley Medical Center,
Release of Information Medical Records, 751 S. Bascom Avenue San Jose, California 95128

Patient/Representative Signature: _____ Date: _____ Time: _____

If signed by other than patient, indicate legal relationship to sign: _____

Signature of witness: _____ Date: _____ Time: _____

MENTAL HEALTH USE ONLY

Complete the following if the patient is the person authorizing release of his/her records subject to California Welfare and Institutions Code Section 5328: The undersigned (the physician, licensed psychologist, or social worker with a masters degree in social work, or marriage and family therapist), who is in charge of the patient, hereby ☐ **Approves** ☐ **Disapproves** the release of information and records to Requestor. If disclosure is disapproved, give reasons below. Also note below or attach any restrictions on the release of records.

_____

_____

Date Physician/Psychologist/Social Worker Credential