



Martin Luther King, Jr.  
Community Hospital

**AUTHORIZATION FOR USE OR DISCLOSURE OF  
PATIENT HEALTH INFORMATION**

**Note: Fees may apply to certain requests**

Martin Luther King, Jr. Community Hospital will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ MRN: \_\_\_\_\_ FIN: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**PURPOSE**

This authorizes Martin Luther King, Jr. Community Hospital to disclose information as specified below for the following purposes: \_\_\_\_\_

**RECIPIENT INFORMATION**

Martin Luther King, Jr. Community Hospital may disclose this information to:

Check if same as above (disclosure to patient) Recipient Name: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

**COPIES OF RECORDS OR MEDICAL RECORD INFORMATION**

Within the Following Dates: \_\_\_\_\_ to \_\_\_\_\_

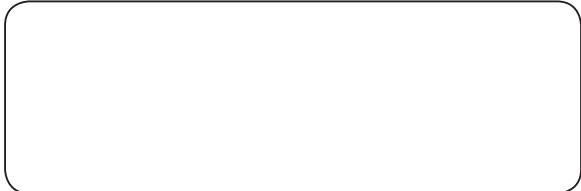
- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Report     | <input type="checkbox"/> Consultation(s)  |
| <input type="checkbox"/> Lab Reports       | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Entire Record     | <input type="checkbox"/> Radiology Reports/CD | <input type="checkbox"/> Billing Records  |

**NOTE: Hospital and Medical Office records may include disclosure of information related to mental health, alcohol/drug, and HIV references contained within those records as part of this authorization.**

**The actual treatment records from mental health, or alcohol/drug departments, or results of HIV antibody tests are specifically protected, and will not be disclosed unless you sign below.**

Mental Health department records → Signature: \_\_\_\_\_  
Alcohol/Drug dependency treatment records → Signature: \_\_\_\_\_  
HIV antibody test results → Signature: \_\_\_\_\_

**MEDIA**  Electronic  Paper **DELIVERY PREFERENCE**  Email/Secure Portal  Mail  Pick Up





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**DURATION**

This authorization shall remain in effect for one year from the date of signature unless a different date is specified here \_\_\_\_\_ (date).

**REVOCACTION**

Your or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

**REDISCLASURE**

Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA). California recipients are required to obtain your authorization before further disclosing this information.

If you are requesting a form to be completed, we may substitute a standardized version of the form that provides the same or similar information requested.

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

Date

Signature

If not patient, print your name and relationship