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 _____

☐ Discharge Summary	☐ Pathology Report	☐ Consultation(s)
☐ Lab Reports	☐ History and Physical	☐ Operative Report
☐ Entire Record	☐ Radiology Reports/CD	☐ 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

Martin Luther King, Jr.
Community Hospital

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

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

REVOCATION 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.

REDISCLOSURE 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