Kaweah Health Medical Group

Medical Records Department
5400 W. Hillsdale Ave, Visalia, CA 93291
Phone: 559-738-7500 ext. 5577
Fax: 559-636-9498

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
ONE PER REQUEST

Media Type
☐ CD/DVD
☐ Paper

Patient Full Name (Print) _____

Last 4 digits of SS#_____ DOB: _____
is requesting that Kaweah Health Medical Group, identified above, release health information: (Check one) ☐**TO** *or* ☐**OBTAIN FROM** the person, company, agency or facility listed below.

Name, Position or Department:_____

Name of Organization:_____

Address of Organization:_____

Phone Number of Organization:_____

The information relates to service dates beginning _____ and ending _____.

☐	Entire record	☐	Medication List	☐	Physical Therapy notes
☐	Demographic Info	☐	Immunizations	☐	Occupational Health Record
☐	History & Physical	☐	Test Results	☐	Other Assessments
☐	Office Visits	☐	Discharge Summary	☐	Medical/Surgical History
☐	Other: (Specify)				

Purpose of the disclosure: ("Request of the individual" is sufficient for patient-initiated releases)

☐	Request of Individual	☐	Change of Doctor	☐	Legal Investigation
☐	Referral to Specialist	☐	Insurance	☐	Workers Comp
☐	Continuing Care	☐	Other: (Specify)		

Note: The patient may be charged a fee to cover labor, copying, and supplies used to reproduce medical records.

_____ (Initial) I realize that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse or mental illness. I give my specific consent for these records to be released.

CONDITIONS and NOTIFICATIONS: This authorization for release of information expires 12 months from the date of patient's signature. You may revoke this authorization at any time by writing to the Custodian of Medical Records at the address listed above. However, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation. You may inspect or request a copy of the health information to be used or disclosed, consistent with federal law. This authorization is being given to the Kaweah Health Medical Group identified above and each practice and entity affiliated with it. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA regulations.

SIGNATURES: I hereby authorize the use or disclosure of the protected health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary and that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

_____ Date: _____

Signature of Patient or Personal Representative:

_____

PRINT Name of Personal Representative

_____

Relationship of Representative to Patient

Released by: _____

(*Department Representative Name*)

Date: _____

Information for Authorization

The privacy and confidentiality of medical, psychiatric and substance abuse information is protected by Federal and State Statutes, Rules and Regulations (including: Health Insurance Portability and Accountability Act, Standards for Privacy of Individually Identifiable Health Information - 45 CFR Parts 160 through 164; California Confidentiality of Medical Information Act; California Administrative Code, Title 22; California Civil Code section 56 et seq. California Welfare and Institutions Code, section 5328; and Title 42 of the Code of Federal Regulations). These Statutes, Rules and Regulations require that the client give informed consent prior to the release of any health/hospital records or information, except as specifically provided for within the Statutes, Rules and Regulations.

California Civil Code section 56.11: An authorization to release health/hospital information will be considered valid only when it states: (1) who will release the information; (2) who will receive the information; (3) the purpose and limitations for which the information will be used; (4) what specific information will be released; and (5) when the authorization will expire. The authorization must also contain the client's/authorized representative's signature and the date of the signature. This Authorization of the Release of Protected Health Information waives any and all rights that the patient now has or may in the future have to bring any legal action against the releasing person/facility for any damages caused directly or indirectly by the release of this information or other confidential information. The authorization must be completely filled out and cannot be missing any required elements.

A minor client may only sign an authorization for the release of their health/hospital information for services, which the minor could lawfully consent. The authorization of their parent or authorized representative is needed for the release of their health/hospital information for services, which the minor could not lawfully consent. The signature of the authorized representative is required for patients who are conservatees under the Probate Code. Authorized representatives signing for the client must submit copies of the legal documents supporting the assignment of this authority.

Upon request, the client will be furnished with a copy of the completed "Authorization for the Release of Medical Information" form.

(Customer Copy)

Kaweah Health Medical Group

Medical Records Department
5400 W. Hillsdale Ave, Visalia, CA 93291
Phone: 559-738-7500 ext. 5577
Fax: 559-636-9498

Authorization to Discuss/Disclose Medical Information

Patient Name_____
Date of Birth _____

Disclosure of Medical Information: Your medical information and communication of such is essential to your care. Kaweah Health Medical Group prefers to speak directly with each patient, but we understand that other individuals or family members may have knowledge of, and be assisting with, your care.

I _____ (patient full name) hereby authorize Kaweah Health Medical Group to discuss/disclose the following information (check as appropriate):

___Appointment Date/Times ___ Medications ___Procedures ___Visit Summary ___Lab/Pathology Results

___ Test Results* (Except for those listed below) ___Radiology/Imaging Results ___ Diagnosis ___ Care Plan

I specifically authorize the discussion/disclosure of the following information (check as appropriate):
__ *Mental Health Treatment Information
__ *HIV Test Results & Treatment Information
__ *Alcohol/Drug Test Results & Treatment Information

A separate authorization is required to authorize the release of psychotherapy notes through the use of the Release of Information process.

Kaweah Health Medical Group cannot discuss your care with any individual without a completed authorization. Please list the individuals with whom we are authorized to discuss your care (a separate form must be completed for each individual):

Name: _____

Relationship: _____

Address: _____

Phone: _____

I understand that:

- I may revoke this authorization in writing by contacting the Kaweah Health Medical Group office
- This authorization is only to discuss/disclose medical information. If I would like a copy of my medical record, a release of information will still be required
- Those listed above will not have access to obtain a copy of my medical record
- This authorization is giving Kaweah Health Medical Group the right to discuss my medical information with those listed above.

Confidential Communication: Communication between Kaweah Health Medical Group practice and you, the patient, is critical to your health. Please list the phone number(s) where we can reach you.

Home: _____ Work: _____

Cell phone: _____ Other: _____

This authorization will terminate in 12 months from date of signature unless otherwise specified here:
_____ (Date of termination. Leave blank if agreeable to 12-month termination)

_____ _____
Patient Signature Date

_____ _____
Patient Full Name (PRINT) Date of Birth

_____ _____
KHMG Representative Date