TWIN CITIES COMMUNITY HOSPITAL
Health Information Management
1100 Las Tablas Rd. Suite 1427
Templeton, CA 93465

_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
(Meets Cal. Civil Code §56.11 and 45 C.F.R.§164.508 Requirements)

Patient's Name: _____
Last First Middle

Address: _____City/State/Zip: _____

Home Telephone: _____ Date of Birth: _____

SPECIFY INFORMATION TO BE DISCLOSED: I authorize Twin Cities Community Hospital to disclose the following information under this Authorization:

☐ Abstract (Face sheet, Discharge Summary, History & Physical, Consult, Operative Report)

☐ ER report ☐ Test Results (lab, x-ray, cardiology, EKG) ☐ Surgical (OP/Path report)

☐ Other _____

DATE(S) OF TREATMENT: _____

MY HIGHLY CONFIDENTIAL INFORMATION:
I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box below, if any such information will be used or disclosed pursuant to this Authorization:
☐ HIV test results (lab report) and/or any other documentation making specific reference to these results.

NAME OF PERSON RECEIVING INFORMATION: (separate request for each receiving party)

Name: _____ Phone No.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

TWIN CITIES COMMUNITY HOSPITAL
Health Information Management
1100 Las Tablas Rd. Suite 1427
Templeton, CA 93465

_____

NOTE to Requestor of Records:
There is a charge for copies of medical records.

TERM:

This authorization will expire on:_____. [Cal. Civil Code §56.11(h)]

(Specific Date)

PURPOSE:

☐ Personal (at request of patient) ☐ New Physician ☐ Primary Care Physician

☐ Social Security Disability ☐ Medical Ins. Claim ☐ Life Insurance ☐ Workers' Comp

☐ Attorney ☐ Other _____

I understand that I have the following rights with respect to this Authorization:

1. The recipient of the protected health information is prohibited from redisclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law.

2. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits.

3. I or my personal representative may revoke this Authorization at any time by mailing or personally delivering a signed, written notice of revocation to Twin Cities Community Hospital, Attn: Health Information Management, 1100 Las Tablas Rd., Templeton, CA 93465. Such revocation will be effective upon receipt, except to extent that the recipient has taken action in reliance on this Authorization.

4. I am entitled to notice if Twin Cities Community Hospital will use or disclose the protected health information for marketing and receive payment for the use or disclosure of my protected health information.

5. Twin Cities Community Hospital will provide me with a copy of this Authorization.

TWIN CITIES COMMUNITY HOSPITAL
Health Information Management
1100 Las Tablas Rd. Suite 1427
Templeton, CA 93465

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Twin Cities Community Hospital to use or disclose my health information in the manner described above.

_____	_____
Signature of Patient/Personal Representative**	**Date**
_____	_____
Personal Representative's Authority To Act on Patient's Behalf	**Printed Name**

Identification of Patient/Personal Representative verified with one of the following by:_____(Initial's)

☐ **Driver's License or Other Legal Photo ID**_____ ☐ **Other/HPF**_____

☐ **Supporting Documentation:**_____

Authorization must be signed by the patient or any other individual who has the legal authority to make health care decisions on the patient's behalf (e.g., person legally obligated to financially support adult patient or designated Agent in an Advance Health Care Directive).
A minor can sign the authorization only if he/she was legally authorized to consent to the care provided.

**** "Personal Representative" is any of the following:**

Incompetent Adult:

-A conservator of the patient's person with court appointment papers
-An agent appointed by patient under an Advance Health Care Directive with copy of DPOAH

Minor

-A Parent
-A Guardian or Other person *in loco parentis* with court appointment papers

Deceased Patient: Copy of Death Certificate and court appointment papers for Executor, Administrator or Small Estate Affidavit if no probate or Beneficiary status documents.

- Executor of Estate
-Administrator of Will
- Proof that requestor is a beneficiary who will receive money or property from estate of a deceased patient