BAY AREA REGIONAL MEDICAL CENTER

Authorization to Release Information

Section A: This section must be completed for all Authorizations.		
Patient Last Name:	First Name:	MI:
Date of Birth:	Social Security Number (optional):	
My health information may be released to (name of recipient):		
Address:		
City:	State:	Zip:

I hereby authorize the use or disclosure of protected health information as described below:

Description of information being disclosed for the following date(s) of service:

❒Complete health record	❒Abstract/Pertinent Information	❒Consultation Reports
❒History/physical exam	❒HIV/AIDS Information	❒Laboratory Reports
❒Progress Notes	❒Drug/Alcohol Treatment Information	❒Emergency Department Records
❒Radiology Reports	❒Discharge summary	❒Other:

Purpose of the Disclosure: (Example: "At the request of the patient")

Expiration: If the health information to be disclosed contains HIV/AIDS or drug and alcohol abuse treatment records, this Authorization expires within sixty (60) days. Otherwise, you may select either of the following expiration events:

❒ 1 year from the date in which I, or my legal representative, signs this Authorization.
❒ Upon the happening of the following event: ____.
(Example: "Upon release of the above records")

I understand that:

1. I may revoke this Authorization at any time by providing written notice to the Director of Medical Records at the address of the facility in which I received my medical care.
2. My revocation will not have any affect on any actions taken by the organization before they received the revocation and is not effective if the Authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim under my insurance policy.
3. The organization will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this Authorization.
4. I have the right to inspect or copy the health information to be used or disclosed pursuant to this Authorization.

TO BE COMPLETED BY THE ORGANIZATION IF THIS AUTHORIZATION IS FOR MARKETING, FUNDRAISING, RESEARCH, OR SALE OF PROTECTED HEALTH INFORMATION:	
The organization will receive financial or in-kind compensation in exchange for using or disclosing the health information described above:	❒ Yes ❒ No

TO BE COMPLETED BY THE ORGANIZATION IF THIS AUTHORIZATION IS FOR PAYMENT:	
Has the patient requested that BARMC not disclose patient information to a health care plan for payment purposes? The patient must have paid BARMC in full, out of pocket, for the item or services.	❒ Yes ❒ No

Signatures: I have read the above and authorize the disclosure of the protected health information as stated.	
Signature of Patient (or Patient's Representative)	Date:
Print Name of Patient (or Patient's Representative)	

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

❒ Power of Attorney	❒Legal Guardian	❒ Surrogate Decision-Maker
❒ Executor or Personal Representative	❒ Parent	❒ Other: __________________________