Woodland Healthcare
CHW

Release of Information Department
1207 Fairchild Court
Woodland, CA 95695-4398
Tel. (530) 668-2605 Ext. 6745
Fax (530) 662-7438

WOODLAND MEMORIAL HOSPITAL
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this documentation authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient: _____ Date of Birth _____

Other names: _____ Telephone Number: _____

Address: _____ City/State/Zip: _____

Medical Records or Account #: _____
(Facility Use only)

I AUTHORIZE: ***WOODLAND MEMORIAL HOSPITAL***
1325 COTTONWOOD STREET
WOODLAND, CA 95695

TO DISCLOSE TO: _____ / Appleby & Company, Inc. _____
(Persons/organizations authorized to ***receive*** the information)

at the following address: **2828 N. Wishon Ave., Fresno, CA 93704**
(street, city, state and zip code)

☐ **THE FOLLOWING RECORDS,** specific types of health information, or records for the date(s) of treatment as specified:

DATES OF SERVICE: _____

☐ Progress Notes	☐ Nurses Notes	☐ X-ray Reports
☐ Laboratory Test	☐ History & Physical	☐ Discharge summary
☐ Operative Report	☐ E.R. Reports	☐ Consultation reports

☐ Other: _____

☐ ***THE FOLLOWING INFORMATION*** contained in the records specified below (**Initial applicable lines and boxes below):**

_☐_ Mental health or developmental disability treatment records (excludes "psychotherapy notes")

_☐_ Substance abuse treatment records

_☐_ HIV test results (This authorizes disclosure of laboratory test results only. **Note that your records may include information concerning you HIV status <u>even</u> if you no not check this box.)**

☐ **ALL RECORDS** regarding my treatment, hospitalization, and outpatient care. ***A separate authorization is required for the use or disclosure of psychotherapy notes or research health information.***

PURPOSE: The purpose and limitation (in any) of the request use or disclosure is:

☐ At the request of the patient or personal representative; ***OR***

☐ Other: _____

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified: _____
(insert date)

MY RIGHTS:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or health eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address ***Woodland Healthcare, Release of Information Dept. 1207 Fairchild Ct., Woodland CA. 95695.*** My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization
- I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed be the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

SIGNATURE: _____ **Date:** _____
(Patient or personal representative)

_____ _____
Print name of personal representative Relationship to patient

Patient/Representative Identification Verified *Intitals:*_____*Dept*

⇨ **PICTURED I.D. MUST BE PRESENTED** ⇦