1ROI

Patient Name: _____ Daytime Phone: _____

Date of Birth: _____

1. I, _____ hereby authorize the use or disclosure of the above named individual's health information as described below.
2. The following organization is authorized to make the disclosure: _____ (Hospital)
3. The type and amount of information to be used or disclosed is as follows (include dates where appropriate). Please check ✓ appropriate box:
   - ☐ ER/OP visits ☐ Dates of Service _____
   - ☐ Entire record
   - ☐ Following portions of the record only: _____
4. Patient access - The type of access requested is: (✓ check one)
   - ☐ Inspection of the record ☐ Copies of the record as described above
5. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
6. This information may be disclosed to and used by the following individual or organization:

   _____

   Address: _____

   for the purpose of: _____
7. I understand I have the right to revoke this authorization at any time as described in the Notice of Patient Privacy Practices. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Services Department, I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

   _____

   If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
8. I understand that authorizing the disclosure of this health information is voluntary; I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact the St. Rose Hospital Privacy Officer.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Witness

St. Rose HOSPITAL
27200 Calaroga Avenue
Hayward, CA 94545

PATIENT LABEL HERE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

(01/18/2018)