St. Rose HOSPITAL
27200 Calaroga Ave. Hayward, CA-94545
Ph: (510) 264-4039 Fax: (510) 264-4094

Authorization to Disclose Protected Health Information

Patient Name _____ Date of Birth _____

Address _____ City/State _____ Zip _____ Phone _____

Purpose of Request: ☐ Continuation of care ☐ Personal ☐ Legal ☐ Insurance ☐ Other _____

I authorize release to (Name) _____ Phone _____

Mailing address: _____ City/State _____ Zip _____

Email address _____ Fax _____

Date of service range (month/year): From _____ To _____

Method of release: ☐ Mail ☐ Encrypted email ☐ in person pick-up ☐ Fax

☐ Patient Portal (Self only) ☐ Other _____

Select the records below:

☐ Visit Summary: includes H&P, Discharge Summary, Provider notes, Reports & Results. Does not include images.

☐ Consultation/Progress notes
☐ Discharge summary
☐ **Drug/Alcohol treatment***
☐ Emergency room report
☐ Facesheet
☐ **Genetic information***
☐ History & Physical
☐ Other _____

☐ Immunization record
☐ Laboratory results
☐ **Mental health treatment***
☐ Operative note
☐ **Perinatal/Reproductive treatment***
☐ Radiology reports
☐ Radiology images
☐ **STD/Communicable diseases***

***I hereby consent to disclose the above bolded specialized information.** _____
(Signature is required)

1. I authorize the release of my medical record, including photographs.
2. This authorization is voluntary and the disclosure is made at my request.
3. If the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
4. Multiple requests are authorized if the purpose of the request remains the same.
5. I have a right to revoke this authorization at any time, and if I revoke this authorization, I must do so in writing and present the written revocation to the department that I have authorized to release the information. Any revocation will not apply to information that has already been released in response to this authorization.
6. I need not sign this form to ensure health care treatment.

I request this authorization to expire on _____ or 180 days from the date signed below and **covers only the date of service range specified above**.

I am also aware that fees (outlined below) may apply.

NOTE: Fees/charges will comply with all Laws and regulation applicable to the release of information. Standard fees are as follows:

To patient: $6.50 all pages (CD or electronic delivery). Patient Portal delivery is free (all pages).
Paper delivery: 1-10 are free, 11-99 pages are $6.50, 100 or more pages are delivered electronically only.
(An initial set of records and images can be provided at no cost to a patient for the physician or disability referral.)

To third party recipient: $0.25 per page for records. Actual cost of reproduction for Radiology images.

_____ _____ _____

Signature of patient or legal representative **(Self/Relation to pt.)** **Date**

FOR HIM OFFICE USE ONLY

Pt MRN _____ Account number _____

Requester ID type/number: ☐ Driver's license/State ID _____ ☐ Government ID _____

If the patient is deceased, indicate documentation: ☐ Death certificate ☐ Power of attorney ☐ Living Will

Processed by _____ Date _____ Forwarded to _____