

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
(AUTORIZACIÓN PARA UTILIZAR Ó DIVULGAR INFORMACIÓN MÉDICA PROTEGIDA)**

Patient Information			
Patient Name:		Also known as:	
Date of Birth: / /		Telephone:	
Record Holder:			
<input type="checkbox"/> Pioneers Memorial Healthcare District			
Records may be released to:			
Name:		Telephone:	
Address:			
City:		State:	
Fax:		Email:	
I would like the Health Information:			
<input type="checkbox"/> Mailed	<input type="checkbox"/> In person	**Emailed: <input type="checkbox"/> Unsecure	<input type="checkbox"/> Faxed
<i>** If you have requested for your medical record information to be sent to you via email, please be advised that this method is not 100 percent secure. Please be aware that once your information leaves Pioneers Memorial Healthcare District, Pioneers Memorial Healthcare District will no longer be able to protect that information.</i>			
<input type="checkbox"/> <i>I agree to have my records sent by email and I understand the risks.</i>			
Health Information to be released			
Date of Service:		<input type="checkbox"/> Hospital Stay	<input type="checkbox"/> ER <input type="checkbox"/> Clinic Visit
<input type="checkbox"/> Radiology	<input type="checkbox"/> Laboratory results	<input type="checkbox"/> Other (Please specify)	
Sensitive Information - I specifically authorize the release of :			
<input type="checkbox"/> HIV	<input type="checkbox"/> Mental Health Records	<input type="checkbox"/> Drug and Alcohol Treatment Records	
Purpose/Use of the Information:			
<input type="checkbox"/> Continued Care	<input type="checkbox"/> Legal	<input type="checkbox"/> Personal	<input type="checkbox"/> Other
I understand that by signing this authorization:			
<ul style="list-style-type: none"> ● I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed ● I understand that I may revoke this authorization at any time by notifying PMHD in writing and will not affect information that has already been used or disclosed. ● I have the right to receive a copy of this authorization. ● I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization. ● I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. ● Unless otherwise stated, this authorization is good for 365 days from date of signature. ● I understand that there is a fee as permitted under California Law for copying records. 			
Name/Signature of Patient or Representative			
Printed Name:		Date:	
Signature:		Relation to patient:	