IMPERIAL VALLEY HEALTHCARE DISTRICT (IVHD) DBA PIONEERS MEMORIAL HOSPITAL
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
(AUTORIZACIÓN PARA UTILIZAR Ó DIVULGAR INFORMACIÓN MÉDICA PROTEGIDA)

Patient Information			**MRN**
Patient Name:			Also known as:
Date of Birth: / /			Telephone:
Record Holder			
□ IVHD dba Pioneers Memorial Hospital □ Other Entity_____			
Records may be released to:			
Name:			Telephone:
Address:			
City:	State:		Zip Code:
Fax:			Email:
I would like the Health Information:			
□ Mailed	□ In person	**Emailed: □ Unsecure	□ Faxed
***** 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 IVHD dbaPioneers Memorial Hospital, IVHD dba Pioneers Memorial Hospital will no longer be able to protect that information.***			
□ ***I agree to have my records sent by email and I understand the risks.***			
Health Information to be released: *(please check all that apply)*			
Date of Service:	□ Hospital Stay	□ ER	□ Clinic Visit
□ Radiology	□ Laboratory results	□ Other (Please specify)	
Sensitive Information - I specifically authorize the release of *(please initial)* **:**			
___Abortion & Related Services Records	___Reproductive Health Services Records		___Gender Affirming Services Records
___ HIV	___Mental Health Records	___ Substance Abuse Records	
Purpose/Use of the Information:			
□ Continued Care	□ Legal	□ Personal	□ Other

I understand that by signing this authorization:

- 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 Pioneers Memorial Hospital 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 futher understand that the information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to HIPAA, or any other state or federal privacy rules.
- 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: *(if other than self)*