San Gorgonio Memorial Hospital 600 N. Highland Springs Ave. Banning, CA 92220
Phone (951) 845-1121 x6205 Fax (951) 769-2113

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information, about you. Failure to provide all information requested may invalidate this Authorization.

☐Mail ☐Pick Up Paper/CD ☐Fax

Patient Name: _____
Date of Birth:_____
Patient Address: _____
_____
Phone Number: _____ Message Number_____

I hereby authorize SAN GORGONIO MEMORIAL HOSPITAL
600 N. Highland Springs Ave.
Banning, CA 92220
Phone (951)-845-1121 x6205
Fax (951)-769-2113

To release to:

_____
_____
_____
(Address, Street, City, State, Zip Code)

The following information:

☐ Emergency Room ☐ History & Physical ☐ Procedure Reports

☐ Discharge Summary ☐ Progress Note ☐ X-Ray Reports

☐ Consultation Reports ☐ Laboratory Tests

☐ Billing Records

☐ Date(s): _____

☐ Other: _____

PURPOSE: This purpose and limitations (if any) of the requested use or disclosure is: □ Patient Request OR □ Other _____

There is a fee for copy of records (exception is records mailed to a physician for continued care).

I specifically authorize release of the following information (check as appropriate):

( ) Mental health treatment information
( ) Substance abuse treatment records
( ) HIV test results (This authorization disclosure of laboratory test results only.
Note that your records may include information concerning your HIV status even if you do not initial this line.

EXPIRATION: This authorization will automatically expire in six months unless otherwise indicated: _____

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or 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:
  San Gorgonio Memorial Hospital, 600 Highland Springs Ave, Banning, CA 92220-3090 Attn. Medical Records

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosures 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: *Initials*____ *Dept.*___

Note: If the substance abuse treatment information is protected by federal confidentiality rules (42 C.F.R. part 2) the following prohibition of re-disclosure statements must be provided to the recipient of the information. The federal rules prohibit from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C. F.R. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.