Please submit completed form(s) to Marshall Medical Center Health Information Management department via fax or mail.

Mailing Address:

1100 Marshall Way
Placerville, CA 95667
Hospital Basement – Attn: HIM Department

Fax: (530) 621-2165

For additional information, please contact Marshall Medical Center Health Information Management at (530) 626-2620

MARSHALL MEDICAL CENTER
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize:	To release my health information to:
_____ *(Name of person/facility to release health information)*	_____ *(Name of person/facility to receive health information)*
_____ *(Street Address, City, State, Zip Code)*	_____ *(Street Address, City, State, Zip Code & Phone No.)*

Type(s) of Health Information to be Released for the following date range: _____ **to** _____

- ❑ Hospital and Medical Clinic Records
- ❑ Radiology Images
- ❑ Verbal Communications Only
- ❑ Hospital Records Only
- ❑ Billing Records
- ❑ Medical Clinic Records Only
- ❑ Other: _____
- ❑ Records limited to the following provider(s) or department(s): _____

The information below is protected by law and will not be released unless you specifically authorize: (This type of sensitive information will not be delivered via Email)

❑ Mental health (other than psychotherapy notes) _____ *(Initial)* *For psychotherapy notes, complete the Authorization for Disclosure of Psychotherapy Notes to Third Parties.*	❑ HIV/AIDS pos/neg test results _____ *(Initial)*
❑ Drug/Alcohol abuse treatment records _____ *(Initial)*	❑ Genetic testing information _____ *(Initial)*

Type of Release:	Delivery Method:
❑ Paper ❑ CD ❑ On-Site Inspection *(Electronic is encrypted)*	❑ Mail ❑ Pick Up ❑ MyChart *(Secure Portal)* ❑ Fax #: _____ ❑ *Email: _____ **Email delivery may increase the risk of your information being released to unauthorized third parties.*

The purpose of this release is for: ❑ Patient/Patient Representative ❑ Other: _____

Your Rights: (1) I may refuse to sign this authorization. (2) My refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits. (3) I may inspect or obtain a copy of the health information that I am being asked to allow the disclosure of. (4) I may revoke this authorization at any time, but I must do so in writing, signed by me or my representative, and submit it to: Marshall Medical Center, Health Information Management, at the above address. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. (5) I have a right to receive a copy of this authorization.

Expiration of Authorization: This authorization expires: _____ (insert date). If no date is indicated, the authorization will expire 12 months after the date of my signing this form.

Notice: Fees may apply for copies of your records. Unless required by law, California law prohibits the recipient from further disclosing your health information without another authorization from you. If you have authorized the disclosure to someone not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Signature: _____ *Print Name* _____ *Signature of Patient or Representative* _____ *Relationship to Patient*

_____ *Date* _____ *Interpreter Signature, if applicable*