MARSHALL

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. PATIENT INFORMATION

Patient Name: _____ Patient DOB: ___/_____/____

2. RELEASING / RECEIVING PARTIES

A. I hereby authorize:
Releasing Facility/Physician:
_____
Street Address/City/State/ZIP:
_____
_____
Contact Information (Phone/Fax/Email):
P: _____ F: _____
E: _____

B. To release my health information to:
Receiving Organization/Individual:
_____
Street Address/City/State/ZIP:
_____
_____
Contact Information (Phone/Fax/Email):
P: _____ F: _____
E: _____

3. PURPOSE OF RELEASE

❑ Transfer of Care ❑ Insurance ❑ Legal ❑ Patient/Patient Representative
❑ Other: _____

4. INFORMATION REQUESTED FOR RELEASE

❑ Hospital Records
❑ Lab Results
❑ Radiology Records
❑ Radiology Images (CD required, $5 fee)
❑ Clinical Records
❑ Immunizations
❑ Provider Progress Notes
❑ AND/OR Other: _____

For Last 2 Years of Care (Transfer of Care) ***OR*** *Date Range Requested __/__/__ to __/__/__*

5. SENSITIVE INFORMATION RELEASE

The information below is protected by law and will not be released unless you specifically authorize:
Note: This type of sensitive information will not be delivered via email.

❑ Substance Abuse:____ (initial)
❑ Mental Health:____ (initial)
❑ HIV/AIDS Test Results: _____ (initial)
❑ Genetics Testing: _____ (initial)

6. DELIVERY METHOD

- ❑ Paper[1] (first 20 pgs free, $0.25/add'l pg)
  - ❑ Pick-Up[3]
  - ❑ Mail
- ❑ Fax
- ❑ USB Flash Drive[2] ($5 fee)
  - ❑ Pick-Up[3]
  - ❑ Mail
- ❑ Email

1. If your paper records have an associated fee, an HIM Technician will contact you with payment information. We only accepted check or money order (payable to: Marshall Medical Center) as payment at this time.
2. Electronic records are released encrypted $ in .pdf format.
3. Pick-up is only at Marshall Hospital, 1100 Marshall Way, Placerville, CA. A photo ID must be present at the time of pickup. Patient's written & signed permission must be present if any other party is picking up.

7. EXPIRATION OF AUTHORIZATION

This authorization expires: _____/_____/_____
If no date is indicated, the authorization will expire **12 months** after the date of you signing this form.

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 1100 Marshall Way, Placerville, CA 95667.* 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.

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.

8. SIGNATURE

Note: Signatures MUST be signed in pen or using e-sign software. Typed signatures are NOT valid.

Signature: _____ *Date:* ____/____/____

Print Name: _____ *Relationship to Patient:* _____

MARSHALL MEDICAL CENTER AUTHORIZATION GUIDE

1. **PATIENT INFORMATION:**
   Please enter the patient's full legal name AND date of birth.
2. **RELEASING/RECEIVING PARTIES:**

   A. **I hereby authorize:** Enter the name of the facility or provider you received treatment. Be sure to include the address, phone, and fax number, if known.

   Marshall Medical HIM Department
   1100 Marshall Way, Placerville, CA 95667
   PHONE: 530-626-2620 | FAX: 530-621-2165
   EMAIL: HIMReleaseOfInfo@MarshallMedical.org

   B. **To release my health information to:** Enter the information for the party receiving records. If these records are for yourself, please include your full name, address, e-mail address, and a phone number where you can be reached. If these records are for another party, please at least include the name of the receiving party and their phone number.

3. **PURPOSE OF RELEASE:**
   Please indicate how you will use the records. This is required by law.

4. **INFORMATION REQUESTED FOR RELEASE:**
   Please check off the types of records you are requesting. The [OTHER] box can be used to input additional information about your request, such as specific types of imaging or lab results. If requesting specific records, please indicate details such as time period, physician's name, procedure type, etc.

   Note: The industry standard for transfer/continuation of care is to only include the previous 2 years of medical history. Your entire record is NOT required. Medical providers' offices can fax a request for additional records from us directly if they require additional information.

5. **SENSITIVE INFORMATION RELEASE:**
   Certain types of medical records are protected by law & require explicit authorization for release. Please check the relevant box/es & initial to indicate we have permission to release these records, if applicable.

6. **DELIVERY METHOD:**
   Please indicate your preferred media & delivery method for your release. Please check ONLY ONE delivery method. Certain methods of release may have associated fees. See form for details.

7. **EXPIRATION OF AUTHORIZATION:**
   Please enter a specific date for the expiration of the authorization. If not specified, the form will be valid for one year from signing.

8. **SIGNATURE:**
   Please sign & date where indicated. This is required by law. We only accept physical signatures in pen or verified electronic signatures (such as through Docusign).
   If you are NOT the patient whose records are being requested: Enter your name & relationship to the patient. Supporting documentation may also be required to authorize the record release.