SIERRA VIEW MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient name: _____

Date of birth:_____ Social security number: XXX-XX-____

Phone number: _____ Email address: _____

Mailing address: _____

City/State/Zip Code: _____

I authorize _____ to release my protected health information to:

Name (of individual or organization): _____

Mailing address: _____

City/State/Zip code: _____

Phone number: _____ Email: _____ Fax number: _____

Type of protected health information to release (select all applicable):

☐ Emergency/Urgent Care Record ☐ Mental Health information (requires separate release)

☐ All hospital medical records ☐ Alcohol/drug information

☐ All hospital billing records ☐ HIV/AIDS testing records

☐ Radiology ☐ Report ☐ CD ☐ Laboratory

☐ EKG/EEG ☐ Pathology

☐ Other (specify portion of records only)

- ☐ Discharge summary ☐ History and Physical ☐ Operative report
- ☐ Progress notes ☐ Consultation notes
- ☐ Other _____

Service dates: _____ to _____

Please note that if no service dates are chosen, records from all service dates will be released. If you do not select psychiatric/psychological/mental health evaluation/assessment information, alcohol/drug information, or HIV/AIDS testing records, Sierra View Medical Center will not release such information.

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

PATIENT'S LABEL

AUTHORIZATION FOR RELEASE OF PHI

Form # 014104 REV 08/18

Authorization purpose (select all applicable):

☐ Personal ☐ Medical (e.g. continuing care) ☐ Legal ☐ Insurance

☐ Other: _____

Protected health information format and delivery method (select only one):

☐ Paper

- ☐ In person
- ☐ Mail
- ☐ Fax

☐ CD/DVD-ROM

- ☐ In person
- ☐ Mail

☐ PDF File (encrypted email only)

Preferred delivery or pickup (if in person), date: _____

Preferred address for mailed records: _____

Preferred secure email address for emailed records: _____

Please note that Sierra View Medical Center may charge to copy records. If you have questions about estimated costs, please contact us at 559-791-4714, at roiinbox@sierra-view.com or in person at 396 W Putnam, Porterville, Ca 93257 from 8:00 AM to 5:00 PM, Monday-Friday (excluding holidays).

Authorization expires one year from the signature date unless an earlier date is indicated:
Date: _____

My Rights:

- I understand that information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California Law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

Sierra View Medical Center is a service of the Sierra View Local Health Care District.

PATIENT'S LABEL

- I further release my attending physician, the hospital and employees of the hospital from any liability arising from the release of information to the person(s)/agency designated above. A photocopy/fax of this authorization is as valid as the original.

- I understand that I may revoke this authorization by sending a letter to the Health Information Management Department, attention Release of Information at 396 W Putnam, Porterville, Ca. 93257

- I have a right to receive a copy of this authorization.

I have read and signed this authorization.

_____ _____ _____
Signature of Patient/Parent/Legal Representative Date Relationship

Authorized representative name: _____

If you are the patient's Legal representative, indicate your relationship to the patient:

☐ Parent ☐ Legal Guardian

☐ Other: _____

_____ _____
Records received by Date

Office use only

Date Requested filled:_____ Time:_____ By: _____

Account #:_____ Medical Record #: _____

Identification presented: _____

Fee collected:_____

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