SIERRA VIEW MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION: (Please use full legal name, no nicknames)

Patient Name: _____ **Social Security Number:** XXX-XX-_____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____/_____/_____ **Phone:** (_____) _____-_____

Email: _____

RELEASE RECORDS TO: (Where do you want records sent?)

I authorize _____ **to release my medical records to**

Name of Hospital/Clinic/Person: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Fax Number:** _____

Email: _____

RELEASE RECORDS TO: (Who do you want to recieve the records?)

If you would like a designee to pick up your records, please fill out section below:**

I authorize _____ **to pick up my medical record copies.**

Relationship to patient: _____

****Note: Designee must provide valid photo ID**

DELIVERY INSTRUCTIONS: (Please select one)

☐ **CD** ☐ **Email (email will be encrypted)** ☐ **Paper Copy**

Purpose (what is the purpose of this release?)

State reason: _____

_____

HEALTH INFORMATION TO BE RELEASED: (What records are being released?)

☐ **Billing Statements**	☐ **Emergency Reports**	☐ **Pathology Reports**
☐ **Consultations**	☐ **History & Physical Exams**	☐ **Progress Notes**
☐ **Discharge Summary**	☐ **Radiology CD**	☐ **EEG**
☐ **Laboratory Reports**	☐ **EKG**	☐ **Operative Reports**
☐ **Radiology Reports**	☐ **Mental Health**	

☐ **Other:** _____

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

PATIENT'S LABEL

AUTHORIZATION FOR RELEASE OF PHI

Form # 014104 REV 01/25

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

SIERRA VIEW MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

SENSITIVE INFORMATION:
(Sensitive information will not be released unless specifically authorized below:)

☐ **Drug and Alcohol Abuse Results** ☐ **Genetic Testing Information** ☐ **HIV/AIDS Test Results**

SPECIFY DATE / TIME PERIOD

Specify date / time period for information selected above

From _____ To _____

EXPIRATION OF AUTHORIZATION

If no date is indicated this Authorization will expire 12 months after the date signed.

SIGNATURE(S)

Patient Name: _____ **Date:** _____

Printed Name: _____

Phone: (_____) _____-_____

If signed by someone other than the patient, indicate relationship to the

patient: _____

Signature of Witness (only if patient unable to sign): _____

Date: _____

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257

PATIENT'S LABEL

COMPLETING AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

To protect our patient's confidential medical information we must have a valid, complete and legible authorization to disclose their health information.

All sections of this authorization must be completely filled out before SVMC is permitted to disclose your protected health information.

NOTICE

SVMC and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

REVOCATION

I may revoke this authorization at any time, provide that I do so in writing and submit it to:

SVMC
Health Information Management
465 W Putnam Avenue
Porterville, California 93257

The revocation will take effect when SVMC receives it, except to the extent that SVMC or others have already relied on it.

I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for:

1) conducting research-related treatment,
2) obtaining information in connection with eligibility or enrollment in a health plan,
3) determining an entity's obligation to pay a claim, or
4) creating PHI to provide to a third party.

I am entitled to receive a copy of this Authorization.

OFFICE USE ONLY

Date request filled: _____ **Time:** _____ **By:** _____

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Porterville, California 93257

PATIENT'S LABEL

AUTHORIZATION FOR RELEASE OF PHI

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