MR #________________

1) **This form authorizes the following HealthCare Provider:**

________________________________________
________________________________________
________________________________________
________________________________________

**To produce a copy of my health information as specified below:**

2) **Patient**
**Name:**________________________________
**Date of Birth:**________________________
**Address:**_____________________________
________________________________________
**City:**____________________ **State:**__________
**Zip Code:**____________________________
**Telephone Number:** (        )________________

3) **Requestor:**
**Name:**________________________________
**Attn:** ________________________________
**Address:**_____________________________
________________________________________
________________________________________
**City:**____________________ **State:**__________
**Zip Code:**____________________________
**Telephone Number:** (        )________________
**Fax Number:** (        )____________________

4) **Purpose:** The health information disclosed may be used for the following purposes:
☐ **For my personal use** ☐ **For Continuing Care**

5) **Media Preference:**
☐ Paper ☐ CD (if available electronically)
***Fees may apply for certain requests***

6) **Delivery Method:**
☐ Mail ☐ Pick-up

7) **COVERING THE PERIODS OF HEALTHCARE (DATES OF TREATMENT)**
**From (date):** ____________________ **To (date):** ____________________

8) **Types of Information to be released:**
☐ Emergency Department Record
☐ Clinic/Progress Note(s)
☐ History & Physical(s)
☐ Discharge Summary(ies)
☐ Operative Report(s)
☐ Pathology Report(s)
☐ Consultations
☐ Radiology Report(s)
☐ EKG(s)
☐ Laboratory Report(s)
☐ Records from External Healthcare Providers
☐ Other ____________________

9) **- Highly Confidential -**
Initial to specifically authorize use and/or disclosure of information.
☐ Mental Health Treatment__________
☐ HIV/AIDS test results or treatment information____________
☐ Substance Abuse____________

**Duration:** This authorization shall remain in effect for 6 months from the date of signature unless a different date is specified here ________________ (date).

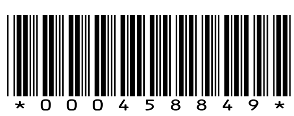
**Revocation:** You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

**Re-disclosure:** Once this health information is disclosed, how the recipient further discloses it may be no longer protected under federal privacy law (HIPAA).

**NorthBay Healthcare will not condition treatment, payment, enrollment, or eligibility for benefits on providing or refusing to provide this authorization.**

10) A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization
**Date:**____________ **Signature:**______________________________________
**If signed by guardian/other please state your legal relationship:**______________________________

1200 B. Gale Wilson Blvd., Fairfield, CA 94533
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION






**FOR NBHC internal use: Identity of requester verified:**_____