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/treatment information_____
☐ Subtance Abuse_____
☐ Genetic Counseling_____

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:_____

NORTHBAY HEALTHCARE AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

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FOR NBHC internal use: Identity of requester verified:_____