El Camino Health

2500 Grant Road, Mountain View, CA 94040-4378
815 Pollard Road, Los Gatos, CA 95032

EL CAMINO HOSPITAL

Telephone: (650)940-7050 | Fax: (650)940-7134

Patient Label

Imaging - Authorization to Release Protected Health Information

Patient's Name:_____
Date of Birth: _____/____/_____ Telephone: _____

I authorize **El Camino Hospital** to release/disclose the following to the recipient listed below:			The purpose of this release is for (check all that apply):
Recipient's Name:			☐ Medical Care
Address:			☐ Personal Use
City:	**State:**	**Zip:**	☐ Other: _____

Date(s) of Service:

Information requested: ☐ Test Results ☐ Images (CD)

Delivery Method: ☐ Mail via USPS ☐ Pick-up in Imaging Department

The following information **WILL NOT BE RELEASED** unless you specifically authorize it by checking the appropriate box(es) below:

□ Information pertaining to drug and alcohol abuse, diagnosis or treatment
□ Information pertaining to psychiatric diagnosis or treatment
□ Information pertaining to HIV / AIDs status

Expiration of Authorization:

Unless otherwise revoked, this authorization expires on _____ or 12 months after the date of my signing this form. I understand:

● This authorization may be revoked in writing at any time, except to the extent that ECH has already disclosed the information. I must submit my revocation to ECH.
● I may refuse to sign this authorization. Treatment may not be withheld or conditioned on obtaining this authorization.
● If disclosure of this health information is to someone who is not legally required to keep it confidential, it may be no longer be protected.
● I have a right to receive a copy of this authorization.

_____ _____
Signature Date

If signed by someone other than patient, indicate legal relationship:_____

□ Power of Attorney for HealthCare / Advance Directive Verified in Epic
□ FYI Restrictions: YES / NO □ Released By: _____ Date: _____

WHITE – PATIENT'S CHART **CANARY** – PATIENT'S COPY