El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

2500 Grant Road, Mountain View, CA 94040-4378

Patient Label

Authorization to Release Protected Health Information

Section 1:

Patient's Name(Last, First):	
Date of Birth:	**Phone Number:**

<u>El Camino Hospital (ECH)</u> is authorized to release protected health information on the above patient to the following recipient :	Name:_____ Address:_____ _____ Phone: _____

Section 2a:

Type of reports to be released:

☐ **Pertinent Information:** includes Physician Reports **<u>AND</u>** all test results (Radiology, Lab, Pathology, EKG)

☐ Other *(specify)*_____

_____

Section 2b:

Specially protected health information:

<u>Initial</u> *below for the release of HIV, Behavioral Health or Drug/Alcohol records*

_____HIV Test Results
_____Behavioral Health
_____Drug/Alcohol

Section 3a:

Date(s) of service: _____

_____

Section 3b:

Purpose:

☐ Continued Medical Care

☐ Patient Request ☐ Other_____

Section 4a

Format: (Select one)

☐ **Paper**

☐ **CD** Records will be provided on ECH electronic media which will be password protected. If mailed, the password will be sent separately.

☐ **MyCare** (Note: You must have an active MyCare account to receive records via patient portal)

Section 4b:

Delivery Method: (Select One)

☐ Mail

☐ Pick up at the HIM Department (Mtn View – Medical Records

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Section 5:

Limitations on use of the information by the recipient: _____

Expiration of authorization: This authorization will expire 1 year from date of signature unless otherwise indicated as follows: _____

Section 6:

Notice of rights and other information:

- I understand that authorizing release of this information is voluntary. If I refuse to sign this authorization, the requested information will not be released.
- Treatment, payment, enrollment, or eligibility for benefits will not be conditional upon this authorization being signed. However, if this authorization is needed for participation in a research study, I may be denied enrollment in the research study.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me (or a legal representative), and delivered to:

  El Camino Hospital – Health Information Management Department
  2500 Grant Road (M/S ECHG23)
  Mountain View, CA 94040
- I understand that the revocation will not apply to information that has already been released based on this authorization.
- Information released based on this authorization could be re-released by the recipient and may no longer be protected by federal law. However, California law prohibits the person receiving health information from further release without authorization unless required or permitted by law.
- I may inspect or obtain a copy of the information for which I am authorizing release.
- I have a right to receive a copy of this authorization.

Section 7:

Signature of Patient or Legal Representative

Print Name: _____

Signature: _____ **Date:** _____

If signed by someone other than the patient, state your legal relationship to the patient: _____ Witness: _____

Health Information Management Department / Medical Records
Phone: 650-988-7462 Fax: 650-988-8246