This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 *et. seq.*

AUTHORIZATION

I hereby authorize ☐ Sonoma Valley Hospital ☐ Other - Specify _____
to release my medical information, as described below, to:
Name: _____
Street Address: _____ City/State Zip: _____
Telephone: _____

INFORMATION TO BE RELEASED

Patient Information: Name of Patient _____
Date(s) of Admission/Service _____ Date of Birth _____
Please check the appropriate box(s) below or describe your request under "Other". ☐ X-Ray Films
☐ Discharge Summary ☐ Lab Results ☐ Emergency Room
☐ Operative / Pathology Reports ☐ X-ray Reports ☐ EKG Reports
☐ Other: _____

_____ initials Psychiatric - I consent to the release of psychiatric diagnosis and treatment information protected by the California Welfare and Institutions Code Section 500 *et seq.*

_____ initials HIV - I consent to the release of the results of the Human Immunodeficiency Virus antibody test and any other HIV testing, diagnosis and treatment information protected by the Health and Safety Code section 199.21.

PURPOSE OF THIS RELEASE

(check one or more)
☐ Inspection of Record ☐ Personal Copy ☐ Insurance ☐ Other _____

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires on: _____ (if no date is indicated; this Authorization will expire six months after the date of signing this form.)

ADDITIONAL RIGHTS (See reverse for more information)

I further understand that I have a right to receive a copy of this authorization upon my request.
Copy requested and received: ☐ Yes ☐ No _____ initials

AUTHORIZING SIGNATURE

_____ _____
Signature of Patient, Parent or Guardian Date of Signature

_____ _____
If signed by other than Patient, indicate relationship Witness

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Sonoma Valley Hospital
Sonoma, CA 95476

* P H I *

Copy: Chart & Patient

Authorization - Sonoma Valley Hospital

Restrictions

California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

Your Rights

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address:

Sonoma Valley Hospital
HIM Department
347 Andrieux Street
Sonoma, California 95476

- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.

California Law permits charging a fee for records. The copy charge is twenty-five cents ($.25) a page if copied from the original record. Pre-payment is necessary to receive any records. There is no charge if records are sent directly to your physician or to another health care facility.

SVH and many other organizations and individuals such a 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.