AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

Medical Record Number : _____
(hospital staff to complete)

Please provide the following information. Please write legibly or print. All items must be addressed to avoid delays in processing your request for information.

Patient Name Tiffany Anderson Phone Number 209-625-8587
Address 2 N Avena Avenue City/State/Zip Lodi CA 95240
Birth Date 8-22-1970

Please send a copy of my medical records to:
Person or Organization to receive information Tiffany Kay Anderson
Address 2 N Avena Avenue City/State/Zip Lodi CA 95240
Phone Number 209-625-8587 Fax Number _____

Purpose of disclosure:	Information to be released:
☐ Continued care ☐ Personal use ☐ Attorney ☐ Insurance ☒ Other (specify) I need medical attention regarding these exposures.	☒ Discharge summary ☒ History and Physical ☐ Operative Report ☒ Lab test - date, type of test (if known) ☐ X-ray – date, type of x-ray (if known) ☐ Other – specify 4-19-04, 5-10-04, 6-9-04, 6-21-04, all labs & vitals, Dr. notes handwritten
Date(s) of admission/procedure 4-04 to 1-05	☒ Unless otherwise specified, I understand that the information to be released may contain HIV or mental health information.

I am providing this authorization voluntarily and understand that treatment, payment, enrollment or eligibility of benefits cannot be conditioned on my signing this document. I understand that I may inspect or copy the information to be used or disclosed. I understand that the information used or disclosed may be subject to redisclosure by the receiving party and then would no longer be protected by federal regulation. I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written authorization to the Medical Records Department of Dameron Hospital. I further understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Please call me to verify

(Att: Patricia Solorio
466-3461 (FAX to)

Medical Record Number : _____
(hospital staff to complete)

This authorization expires on (please provide a date or an event when the authorization will not longer be valid)
June 2014.
If no date is specified, this authorization will automatically expire in six (6) months from the date of my signature below.

[signature] 2-18-2014
Signature of patient or personal representative Date

Tiffany Anderson
(print name of personal representative)

Self
Relationship of personal representative

This section to be completed by Dameron staff:
Name and signature of person receiving information and verification of identification of the requestor:

- ☐ I have verified the requestor's identity by the following:
- ☐ Valid picture identification from state of federal government
- ☐ Copy of death or birth certificate
- ☐ Properly executed power of attorney
- ☐ Other documentation

  _____

- ☐ I provided the requestor with a copy of the information sheet regarding the price for copies (if applicable) and the timeframe to expect a response to the request.
- ☐ I checked the authorization to ensure that all items have been addressed

Additional information regarding this request:

_____ _____ _____
Name (please print) Signature Date