Medical Records ext. 3124 Patricia

Patricia ext 461-3124

REC'D AUG 1 0 2009

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

Medical Record Number: 62-60-41
(hospital staff to complete)

6-20-08 XRO
6-20-08 XRO
11-1-05 OPC
6-9-04 OPC

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 Kay Anderson Phone Number 209-263-7132
Address 1516 Sylvan way #205 City/State/Zip Lodi CA 95242
Birth Date 8-22-1970

Please send a copy of my medical records to:
Person or Organization to receive information Tiffany Anderson
Address 1516 Sylvan Way #205 City/State/Zip Lodi CA 95242
Phone Number 209-263-7132 Fax Number Same / as home

Purpose of disclosure:	Information to be released:
☐ Continued care	☑ Discharge Summary
☑ Personal use	☑ History and Physical
☐ Attorney	☑ Operative Report
☐ Insurance	☑ Lab test - date, type of test (if known)
☐ Other (specify)	☑ X-ray - date, type of x-ray (if known)
	☐ Other - specify
1-26-05 6-09-04 11-1-05	all documents on file regarding my health or lack there of. from 4-04 to current date 8-09
Date(s) of admission/procedure 1-21-05 & 10-1-05 2 seperate incidents	☑ 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.

FORM NO. MR-8700-935 (1/8/09)

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

MOUNTAIN VALLEY PHOTOCOPY
AUG 27 2009
COPIED

Medical Record Number:_____________
(hospital staff to complete)

This authorization expires on (please provide a date or an event when the authorization will no longer be valid)

12-1-09

If no date is specified, this authorization will automatically expire in six (6) months from the date of my signature below.

Signature of patient or personal representative — Date: 8-4-09

Tiffany Kay 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

AUG 27 2009