Patient Name:	DOB:	*MR#:*____________________*(office use only)*

I authorize ____ to release PHI to:
(name of person/facility which has information)

____
*(name of person/facility to **RECEIVE** PHI)*

Address: ____

City, State, Zip Code: ____

I would like to request a:	☐ **PAPER** copy	☐ Mail to above address
I request to receive my copies:	☐ Will pick up	Phone:_______________________

SPECIFY HEALTHCARE FACILITY FROM WHICH PHI IS REQUESTED
☐ Hospital, 300 Canal Street, King City, CA 93930 (831) 385-7235 Fax (831) 385-0366
☐ King City Clinic, 210 Canal Street, King City, CA 93930 (831) 385-7100 Fax (831) 385-5940
☐ Greenfield Clinic, 467 El Camino Real, Greenfield, CA 93927 (831) 674-0112 Fax (831) 674-4199
☐ Specialty Clinic, 400 Canal Street, Suite B, King City, CA 93930 (831) 386-7401 Fax (831) 386-7402
☐ Women's Center, 400 Canal Street, Suite C, King City, CA 93930 (831) 385-7200 Fax (831) 385-5940
☐ Physical Therapy, 809 Broadway Street, Suite C, King City, CA 93930 (831) 385-6835 Fax (831) 385-6686
☐ Family Medical Center, please contact Health Information Management (831) 385-7235 Fax (831) 385-0366

TYPE OF RECORDS	
☐ Medical	☐ Mental Health (other than psychotherapy notes)

INFORMATION TO BE RELEASED		
☐ Discharge Summary ☐ Billing Statements ☐ Pathology Reports ☐ EKG ☐ Progress Notes ☐ Drug & Alcohol Abuse Info. ☐ Laboratory Reports	☐ Outpatient Clinic Records ☐ Emergency Medicine Reports ☐ History and Physical Exams ☐ Consultations/Evaluations ☐ Genetic Testing Information ☐ Operative Reports	☐ Radiology and other Diagnostic **Reports** *(HIM)* ☐ Radiology and other Diagnostic **Images** (x-rays, etc.) *(Radiology)* ☐ HIV/AIDS Test Results ☐ HIV/AIDS Treatment Information
☐ Other____		

Authorization for Use and Disclosure of (PHI) Protected Health Information

8700.004 (Rev. 8/22/17 – FINAL)

Patient Name:	DOB:	*MR#:____________________(office use only)*

Specify date and/or time period for information selected above: ________________________

THE PURPOSE OF THIS RELEASE IS *(check one or more)*:
☐ At the request of the patient/patient representative
☐ Other (state reason)____
Initials of Patient or Legal Representative: _______________

NOTICE: Mee Memorial Hospital and Clinics and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS:

- I understand this authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create PHI to provide to a third party.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to Health Information Management, Mee Memorial Hospital and Clinics, 300 Canal Street, King City, CA 93930. The revocation will take effect when Mee Memorial Hospital and Clinics received it, except to the extent that Mee Memorial Hospital and Clinics or others have already relied on it.
- I am entitled to receive a copy of this authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization expires ____________________ *(insert applicable date or event).* If no date is indicated, this authorization will expire **12 months** after the date of signing this form.

Patient Name:	DOB:	*MR#:*____________________*(office use only)*

SIGNATURE
Date: ____________________ Time:____________________ am / pm Signature:____ *(patient/legal representative)* If signed by a person other than the patient, indicate relationship: ______________________ Print name: ____ *(legal representative)*

MEE MEMORIAL HOSPITAL AND CLINICS
Release of Information
300 Canal Street, King City, CA 93930
Phone: (831) 385-7235 / FAX: (831) 385-0366

Office use only

Patient called when ready:	Date/Time:_________________	Patient/Representative picked up:	Date/Time:______________________
Name:____________________	Title:_____________________	Signature:____	