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 ☐ Marin General Hospital ☐ Other - Specify ____________
to release my medical information, as described below, to:

Name: ____________
Street Address: ____________
City/State/Zip: ____________

INFORMATION TO BE RELEASED

Patient Information: Name of Patient ____________
Date(s) of Admission/Service ____________ Date of Birth ____________

Please initial the appropriate box(s) below or describe your request under "Other".

☐ X-Ray Films Available in Radiology Dept.

☐ Discharge Summary ☐ Lab Results ☐ Emergency Room
☐ Operative / Pathology Reports ☐ X-ray Reports ☐ EKG Reports
☐ Other: ____________
☐ Psychiatric - I consent to the release of psychiatric diagnosis and treatment information protected by the California Welfare and Institutions Code Section 500 *et. seq.*
☐ 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.

USE AND RESTRICTIONS

The recipient may use the information for the following purpose: ____________

____

The recipient may not further use or disclose the information unless other written authorization is obtained (except where specifically required or permitted by law).

Special instructions or restrictions: ____________

DURATION

This authorization shall become effective immediately and shall remain in effect until ____/____/____

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

24140 (7/23/08)

Marin General Hospital
A Sutter Health Affiliate

250 Bon Air Road
Greenbrae, CA 94904
(415) 925-7000
FAX (415) 461-5649

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

PATIENT INFORMATION

Name: ____________
Telephone: ____________

FAX BACK TO: (415) 461-5649

MRN (HIM USE ONLY): - - - -

ORIGINAL - MEDICAL RECORD COPY YELLOW - PATIENT COPY

Authorization - Marin General 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:

  Marin General Hospital
  HIM Dept.
  250 Bon Air Road
  Greenbrae, California 94904
- 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.