



General Authorization for Use or Disclosure of Protected Health Information

Patient Name (print name) _____

Patient's Date of Birth _____ Today's Date: _____

Authorization: I hereby authorize _____ to use or disclose information to:

Recipient _____

Address _____

Phone numbers, fax numbers, etc. _____

The recipient may use my Health Information only for the following purposes:

Information Requested: Hospital and Date(s) of service: _____

I authorize disclosure of the information described below (check all that apply):

Table with 3 columns: Entire Medical Record, Pathology Reports, Discharge Summary, History And Physical Exam, Consultation Reports, Progress Notes, Laboratory Test Results/Reports, X-Ray Films/ Reports/Digital Images, Operative Report, Emergency Room Record, Mental Health Records, HIV Results, Other:

Expiration: This authorization expires (enter date) _____.

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/permitted by law. This protection does not extend to recipients outside California.

Your Rights:

- You may refuse to sign this authorization and your refusal will not affect your ability to obtain treatment or payment.
You may revoke this authorization at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to this address: Eden Medical Center, Privacy Officer, 20103 Lake Chabot Road, Castro Valley, CA 94546.
Your revocation will be effective upon receipt, but will have no impact on uses or disclosures made while your authorization was valid.
You have a right to receive a copy of this authorization. If this box [] is checked, you requested and received a copy. Initials_____
You may inspect and obtain a copy of the health information authorized for use or disclosure.
If this box is checked [], EMC will receive compensation for the use or disclosure of your health information.

Your Signature:

Patient/ Representative Signature _____ Relationship to patient: _____

Proof of relationship to patient: _____ Verified by: _____

Verified by Photo ID Matching Signature Other _____