Stanford Health Care
300 Pasteur Drive
Stanford, CA 94305
Phone: 650-723-5721

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

When you complete and sign this form, health information about you will be released as you describe in the form. Please read carefully and complete the required sections before signing. We suggest you request your own copy of your records and review them before authorizing the release of the records to someone other than you. Please clearly and legibly print all information when completing this form and sign on the last page.

SECTION A: PATIENT INFORMATION

*Last name:*_____ *First name:*_____ *MI:*_____

Date of birth: _____ *Phone number:* _____

SECTION B: AUTHORIZATION

Please check the box next to the facility or other provider authorized to **disclose** the information:

❑ **Stanford Health Care** 300 Pasteur Drive Stanford, CA 94305 T: 650-723-5721 • F: 650-725-9821	❑ **Stanford Medicine Partners** 7999 Gateway Blvd #200 Newark, CA 94560 T: 510-731-2675 • F: 510-731-2643
❑ **Stanford Health Care Tri-Valley** 5555 W. Las Positas Blvd. Pleasanton, CA 94588 T: 925-373-8019 • F: 925-373-4126	**Specify Clinic** Name: Address:

Please specify the one person or institution you authorize to receive your health information:

DISCLOSE TO:_____
(Person/organization authorized to receive the information)

at the following address:_____
(Street)

_____
(City, State and Zip Code)

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SECTION C: THE HEALTH INFORMATION

Please specify the specific health information you would like released. Certain specific health information requires a separate indication from you before we release that information, such as HIV test results, hereditary disorder test results, family planning services and certain mental health information. If you would like this information released, you must indicate separately in the boxes C.2, C.3, C.4, and C.5. ***You must both check the box and initial next to the box to authorize the release of the information described after the box.*** Otherwise, the information described in those sections will **not** be released if you simply check off Section C.1.

C.1: General Health Information Release

Please note: This section also authorizes the release of mental health records, except as noted in C.2.

❑ _____Check here ***and initial*** next to the box if you would like information related to specific dates of service released and not the entire medical record.

Indicate dates of service: _____

❑ _____Check here ***and initial*** next to the box if you would like to further describe the health information that you would like released, and please provide a description:_____

_____

❑ _____Check here ***and initial*** next to the box if you would like your entire medical record released.

❑ _____Check here ***and initial*** next to the box if you would like a digital copy of your radiology images released on a CD/DVD.

❑ _____Check here ***and initial*** next to the box if you would like your billing records released.

C.2: Mental Health Information

❑ _____ Check here ***and initial*** next to the box if you had inpatient psychiatric services provided in the G2 or H2 hospital unit (Stanford Health Care), or Legends Unit (Stanford Health Care Tri-Valley) and you would like these records released. Please note that the physician, licensed psychologist, social worker or marriage/family therapist who was in charge of your care may deny release of your information in limited circumstances.

❑ _____ Check here ***and initial*** next to the box if you had outpatient psychiatric services provided in the SHC Outpatient Psychiatric Clinic located at 401 Quarry Road, Palo Alto, CA and you would like these records released. Please note that the physician, licensed psychologist, social worker or marriage/family therapist who was in charge of your care may deny release of your information in limited circumstances.

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❑ _____ Check here ***and initial*** next to the box if you had outpatient psychiatric services provided in the Outpatient Sports Psychology Arrillaga located at 341 Galvez Street, Stanford, CA and you would like these records released. Please note that the physician, licensed psychologist, social worker or marriage/ family therapist who was in charge of the your care may deny release of your information in limited circumstances.

IMPORTANT NOTE ABOUT MENTAL HEALTH INFORMATION: If you received mental health services, such as psychiatric consult, when you were an inpatient not on the G2 or H2 (Stanford Health Care), or Legends Unit (Stanford Health Care Tri-Valley) hospital inpatient psychiatric units or when you were an outpatient in one of the outpatient clinics other than Outpatient Psychiatric Clinic at 401 Quarry Road, Palo Alto, CA, or Sports Psychology at Arrillaga, 341 Galvez Street, Stanford, CA, the mental health notes in your general record will be released when you check the boxes in Section C.1. We will release all information in the general record as you indicate in C.1, which may include mental health notes if you were seen in locations other than the inpatient psychiatric unit or the outpatient psychiatric clinic. We will not exclude or redact information that is included in the general record for releases that you authorize under Section C.1, including mental health notes in the general record. We encourage you to request a copy of your records and review them before authorizing the release of the record.

C.3: HIV Lab Test Results

❑ _____ Check here ***and initial*** next to the box if you had HIV tests performed and would like the HIV test results released.

C.4: Hereditary Disorder Test Results

❑ _____ Check here ***and initial*** next to the box if you had Hereditary Disorder tests performed and you would like the Hereditary Disorder test results released. Hereditary Tests include antenatal, neonatal, childhood and adult hereditary disorder screening records and/or related genetic counseling services *provided in the Genetic Counseling Department* (all test results and records generated as part of the Hereditary Disorders Program). The release of this information may involve the following risks: re-disclosure by the recipient of Hereditary Disorder test results, loss or compromise of insurance benefits or employment status. The release of this information may involve the following benefits: predetermination of genetic conditions, coordination of care and treatment options. You should consult your physician concerning the risk and benefits of releasing specific tests.

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C.5: Family Planning Services

❑ _____ Check here ***and initial*** next to the box if you had California Family Planning, Access, Care and Treatment (FPACT) services and would like this information released. FPACT services may include clinical services, drug and supply services or laboratory services provided at the Gynecology Clinic (GYN) or the Reproductive Endocrinology and Infertility Clinic (REI). If a minor has received family planning services, the release of these records requires authorization from the minor.

SECTION D: DELIVERY FORMAT(S)

You would like this information released in the following format: *(Select one of the following)*

❑ Paper Copy ❑ CD/DVD ❑ Electronic PDF File

You would like this information released via the following method: *(Select one of the following)*

❑ Mail

❑ Fax (Continued Care Requests Only) Provide Fax number:_____

❑ Secure Email: Provide Email address:_____

❑ MyHealth

SECTION E: REASON

Please indicate the reason you would like your health information released.

❑ Check here if you are the patient and you do not want to provide the reason.

❑ Check here if the release is not to the patient and provide the reason for the release here:

_____

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SECTION F: EXPIRATION

This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified: _____

(insert date)

SECTION G: YOUR PRIVACY RIGHTS

- You may refuse to sign this authorization. Your refusal will not affect your ability to obtain treatment or insurance payment or eligibility for benefits.
- You may revoke this authorization at any time, but you must do so in writing and submit it to the following address: Stanford Health Care, 300 Pasteur Drive, MC6330, Stanford, CA 94305. Your revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- You have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such redisclosure, in some cases, may not be protected by state and federal law. Please note that if you wish to impose restrictions on the recipient's use of the health information, you must contact the recipient directly.

SECTION H: CAUTIONS BEFORE SIGNING

- Any health information that will be released as a result of you signing this authorization could be redisclosed by the recipient. If this occurs, your re-disclosed health information may no longer be protected by state or federal privacy law.
- We encourage you to request a copy of your records and review them before authorizing the release of the records to someone other than you.
- The release of this information may involve certain risks, such as re-disclosure by the recipient, loss or compromise of insurance benefits, or employment status.
- If you have questions about this authorization form or the release of your health information, please contact the Stanford Health Care HIMS Department at 650-723-5721, Stanford Medicine Partners HIMS Department at 510-731-2675 or Stanford Health Care Tri-Valley HIMS Department at 925-373-8019, before signing this form.

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SECTION I: CONFIRM AUTHORIZATION

Please sign and date this form to authorize Stanford Health Care, Stanford Medicine Partners and/or Stanford Health Care Tri-Valley to release your information as stated on this form.

Name of patient (please print):_____

Name of legal representative signing this form, if applicable (please print):_____

*Relationship to patient:*_____

Address of patient or legal representative signing this form (please print): _____

Phone number of patient or legal representative signing this form:_____

If you are not the patient and you are signing this authorization form, describe your authority to sign on behalf of the patient and **PLEASE PROVIDE SUPPORTING LEGAL DOCUMENTATION:**

_____

_____

Signature of patient or legal representative:

_____ Date:_____

A COPY OF THIS AUTHORIZATION FORM MUST BE GIVEN TO THE REQUESTOR

SECTION J: If you choose to return this form via mail, please select one of the following facility mailing addresses:

❑ **Stanford Health Care** Health Information Mgmt., MC 6330 300 Pasteur Drive Stanford, CA 94305 T: 650-723-5721 • F: 650-725-9821	❑ **Stanford Health Care Tri-Valley** Health Information Management 1111 East Stanley Blvd. Livermore, CA 94550 T: 925-373-8019 • F: 925-373-4126
❑ **Stanford Medicine Partners** Health Information Management Services 7999 Gateway Blvd. #200 Newark, CA 94560 T: 510-731-2675 • F: 510-731-2643	Space intentionally left blank

Patient/Representative Identification Verified: ***Staff Initials:***_____

Dept.:_____

(For Office Use Only)