

I authorize Sonoma Valley Hospital (SVH) to release health information to:

Self Persons/Organization authorized to receive the information

Name of Person: _____

Street Address, City, State, Zip Code

1. Patient Name _____ **Date of Birth** _____ **Phone** _____

2. The purpose of this release is (check one or more)

Inspection of Record Personal Copy Insurance Other _____

3. Information to Release **Dates of Treatment** _____

Reports (discharge summary, history & physical, operative) ER Reports

Laboratory Standing Lab Orders Imaging All records

Outpatient Other _____

SPECIAL AUTHORIZATION

HIV Test Results Mental Health Drug & Alcohol Abuse Conditional

I acknowledge that data to be released may include material that is protected by Federal and State Laws and that it is applicable to one or more of the following above conditions. My signature below authorizes release of all such information.


Patient/Patient Representative Signature

Date

4. Expiration of Authorization Unless otherwise revoked, this Authorization expires on: _____ (if no date is indicated; this Authorization will expire 12 months after the date of signing this form.)

Date _____ Time _____ AM/PM

Signature of Patient or Patient's Legal Representative

Signature of Witness _____ Continue on back 

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Sonoma Valley Hospital
Sonoma Valley Healthcare District
Sonoma, 95476

5. Fees _____ Patient Initials

California Law permits charging a fee for records. The copy charge is twenty-five cents (\$.25) a page if copied from the original record. Pre-payment is necessary to receive any records. There is no charge if records are sent directly to your physician or to another health care facility. There is no charge if requesting lab results.

6. Notice _____ Patient Initials

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

7. My Rights _____ Patient Initials

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time, provided that I do so in writing and submit to:

Sonoma Valley Hospital
 Health Information Department
 347 Andrieux Street,
 Sonoma, CA 95476.

- The revocation will take effect when Sonoma Valley Hospital receives it, except to the extent that Sonoma Valley Hospital or others have already relied on it.
- I am entitled to receive a copy of this Authorization.

**AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION**

Sonoma Valley Hospital
 Sonoma Valley Healthcare District
 Sonoma, 95476