BAKERSFIELD HEART HOSPITAL

3001 Sillect Avenue
Bakersfield, CA 93308
Phone # 661-316-6000
Fax # 661-852-6355

RELEASE OF INFORMATION AUTHORIZATION FORM

Failure to provide all information requested may invalidate this authorization

Patient Name_____ Date of Birth_____
Address_____ Social Security #_____
Hospitalization Date(s)_____ Medical Record #_____

I authorize the use or disclosure of the above named individual's health information as described below. The following individual(s) or organization(s) are authorized to make the disclosure:

Name: Bakersfield Heart Hospital Medical Records
Address 3001 Sillect Ave Phone # 661-316-6024

The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated): **Most recent reports will be provided unless otherwise requested.**

☐ History and Physical ☐ Operative Report(s) ☐ EKG

☐ Discharge Summary ☐ Pathology Report(s) ☐ Entire Record

☐ Laboratory Report(s) ☐ Radiology Report(s)

Consultation reports from: (Please supply doctor's name)_____
Other (please describe)_____

I understand that a separate consent specific to the information in my health record relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), information about behavioral or mental health services, and treatment for alcohol and drug abuse, is required.

The information identified above may be used by or disclosed to the following individual or organization:
Name_____
Address_____ Phone #_____

Via: ☐ US Mail ☐ Hand Delivery ☐ Fax ☐ Other:_____

This information for which I'm authorizing disclosure will be used for the following purpose:
☐ My personal records Other (please describe)_____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent to a claim under policy.

This authorization will expire (insert date)_____
(If I fail to specify an expiration date, this authorization will expire six months from the date on which it was signed.)

I understand that once the above information is disclosed, the recipient may re-disclose the information and federal privacy laws or regulations may not protect it. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____ _____ _____
Patient Signature or Legal Representative Date Relationship to Patient Date

Date Sent:_____ By:_____ # of Pages: _____

Medical Records
2901 Sillect Ave, Suite 200
Bakersfield, CA 93308
Phone # 661-316-6024
Fax # 661-852-6355