



TAHOE FOREST HOSPITAL DISTRICT



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of healthcare information relating to testing, diagnosis, or treatment for:

- Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV
(Human Immunodeficiency Virus).
Sexually Transmitted Diseases
Treatment for alcohol and/or drug abuse

This Authorization Expires:

NOTICE OF RIGHTS AND OTHER INFORMATION

- I may refuse to sign this Authorization.
I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address:
Tahoe Forest Hospital District
c/o Medical Records
P.O. Box 759
Truckee, CA 96160
My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
I have a right to receive a copy of this authorization.
Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained for me or unless such disclosure is specifically required or permitted by law.
I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
If this box is checked, the Requestor will receive compensation for the use or disclosure of my information.

Patient Signature:

Date: Time:

Authorized Representative Signature:

If signed by someone other than the patient, state your relationship to the patient:

Proof of this relationship:

Custodian Releasing Records:

(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be disclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.)



TAHOE FOREST HOSPITAL DISTRICT



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of healthcare information relating to testing, diagnosis, or treatment for:

- Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV
- (Human Immunodeficiency Virus).
Sexually Transmitted Diseases
- Treatment for alcohol and/or drug abuse

This Authorization Expires: _____

NOTICE OF RIGHTS AND OTHER INFORMATION

- I may refuse to sign this Authorization.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address:
Tahoe Forest Hospital District
c/o Medical Records
P.O. Box 759
Truckee, CA 96160
- My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
- I have a right to receive a copy of this authorization.
- Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained for me or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
- If this box is checked, the Requestor will receive compensation for the use or disclosure of my information.

Patient Signature: _____

Date: _____ Time: _____

Authorized Representative Signature: _____

If signed by someone other than the patient, state your relationship to the patient:

Proof of this relationship: _____

Custodian Releasing Records: _____

(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be disclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.)