



Note: Fees may apply to certain requests

<p>Use or Disclosure: I hereby authorize (<i>select appropriate JMH entity or location below</i>):</p> <p> <input type="checkbox"/> Walnut Creek Medical Center <input type="checkbox"/> Concord Medical Center <input type="checkbox"/> Behavioral Health Center <input type="checkbox"/> Physician Network Practice Office (<i>specify practice location below</i>): _____ <input type="checkbox"/> Other (<i>specify</i>): _____ </p>	
<p>To release health information to:</p> <p>Name of person or facility to receive health information (full address): _____</p> <p>Street address: _____</p> <p>City, State, Zip Code: _____</p> <p>Email: _____</p>	<p>The purpose of this release is for (check one or more):</p> <p> <input type="checkbox"/> Continuity of care or discharge planning <input type="checkbox"/> Billing and payment of bill <input type="checkbox"/> At the request of the patient/patient representative <input type="checkbox"/> Other (<i>state reason</i>) _____ _____ <i>Limitations, if any:</i> _____ _____ </p>
<p>Additional Receiving Parties (Behavioral Requests Only): Psychiatrist: _____ Therapist: _____ PCP: _____ Other: _____</p>	
<p>Requested Format: <input type="checkbox"/> Paper (charges apply) <input type="checkbox"/> CD (charges apply) <input type="checkbox"/> Encrypted Email <input type="checkbox"/> Other (<i>specify</i>): _____</p>	
<p>Delivery Preference: <input type="checkbox"/> Mail <input type="checkbox"/> Pickup <input type="checkbox"/> Encrypted Email <input type="checkbox"/> MyChart Patient Portal <input type="checkbox"/> Other: _____</p>	
<p>Please specify the health information you authorize to be released.</p> <p> <input type="checkbox"/> Hospital Records <input type="checkbox"/> Outpatient Records <input type="checkbox"/> Imaging Reports <input type="checkbox"/> Imaging Films <input type="checkbox"/> Lab <input type="checkbox"/> Procedure/Operative Reports <input type="checkbox"/> Billing <input type="checkbox"/> Immunizations <input type="checkbox"/> Other: _____ Date(s) of treatment: _____ </p>	
<p>The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:</p> <p> <input type="checkbox"/> _____ Information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. Part 2). <input type="checkbox"/> _____^{initial} Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §5328, <i>et seq.</i>) <input type="checkbox"/> _____ Release of HIV test results (Health and Safety Code §120980(g)). <input type="checkbox"/> _____^{initial} Release of genetic testing information (Health and Safety Code §124980(j)). <input type="checkbox"/> _____^{initial} </p>	
<p>Expiration: This authorization expires on (date): _____. If blank, authorization will expire in 1 year from date of signature.</p>	
<p>Signature: _____ Date: _____ Time: _____ Phone: _____</p>	
<p>Print Patient Name: _____ Date of Birth: _____</p>	
<p>Print Requestor Name (if other than patient, documentation may be required): _____</p>	
<p>Relationship to Patient: <input type="checkbox"/> Legal Representative <input type="checkbox"/> Spouse <input type="checkbox"/> Parent (Minor consent may be required) <input type="checkbox"/> Guardian <input type="checkbox"/> Conservator <input type="checkbox"/> Beneficiary</p>	

RELS-36 (4/29/21)

ID VERIFICATION (TYPE)

PATIENT LABEL



ID VERIFIED BY

PRINT NAME:

DOB:

MRI:

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Authorization for Use or Disclosure of Protected Health Information

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization. Please mail completed form to the appropriate John Muir Health entity where treatment or services were rendered. To inquire about the status of your request, please call the phone number of the appropriate entity Health Information Management department listed below.

Location of Treatment/Services	Where to Submit Request
Concord Medical Center 2540 East Street Concord, CA 94520 94520	Health Information Management (him@johnmuirhealth.com) 5003 Commercial Circle, Concord CA 94520 (925) 947-5373 FAX: (925) 947-3235
Walnut Creek Medical Center 1601 Ygnacio Valley Road Walnut Creek, CA 94598	Health Information Management (him@johnmuirhealth.com) 5003 Commercial Circle, Concord CA 94520 (925) 947-5373 FAX: (925) 947-3235
Behavioral Health Center 2740 Grant Street Concord, CA 94520	Health Information Management (him@johnmuirhealth.com) 5003 Commercial Circle, Concord CA 94520 (925) 674-4105 FAX: (925) 692-5741
Physician Network Practices	Health Information Management (him@johnmuirhealth.com) 5003 Commercial Circle, Concord CA 94520 (925) 947-5373 FAX: (925) 947-3235

My Rights

- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits, except in the following circumstances:
 - o When the authorization is for eligibility, enrollment, underwriting or risk rating determination.
 - o When the sole purpose for creating the requested protected health information is to disclose to a third party.
 - o For research related treatment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or an authorized legal representative, and delivered to the appropriate John Muir Health entity and location where the original authorization request was submitted (see above). My revocation will take effect upon receipt, except to the extent those others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure in some cases is not prohibited by California law and may 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 from me or unless such disclosure is permitted or required by law.

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION