SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

Department logo & contact can be inserted here. (VMC, PH, BH, Custody, VHP)

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1

Patient Name:_____
Date of Birth:_____
ID or Medical Record #_____
Address:_____
City:_____
State:_____ Zip Code:_____
Tel:_____

2 AUTHORIZATION: I give permission to _____to use and release to
Recipient Name:_____
Address:_____
Phone:_____Fax:_____

3 PURPOSE: The health information disclosed may only be used for the following purpose(s):_____
_____
_____

4 INFORMATION TO BE RELEASED (Check the appropriate box)

A. MEDICAL
- ☐ All health information (e.g. diagnosis, test results, treatment); OR
- ☐ X-Ray ☐ Images and/or Films ☐ Reports ☐ Billing
- ☐ Only the following information_____
  - ➢ Clinic location can be selected from Attachment B_____ Dated from_____ to_____

B. HIV/AIDS TEST RESULTS (A separate authorization is required for each disclosure.) - Initials: _____

C. DRUGS & ALCOHOL TREATMENT - Initials:_____
- ☐ All drugs & alcohol information (e.g. diagnosis, test results, treatment, billing, attendance); OR
- ☐ Only the following information_____

D. MENTAL HEALTH - Initials:_____
- ☐ All mental health information (e.g. diagnosis, test results, treatment, billing); OR
- ☐ Only the following information_____
  - ➢ Clinic location can be selected from Attachment B_____Dated from_____ to_____

5 DELIVERY PREFERENCE:
☐ Mail ☐ Pick up ☐ Fax

6 DELIVERY FORMAT:
☐ CD ☐ Film ☐ Paper ☐ Verbal

7 DURATION: This authorization is valid immediately and will be valid until_____(*give date*). If I do not write in a date, it will expire twelve months from the date it was signed.

8 CANCELLATION: I understand that I have a right to cancel this authorization any time. A cancellation (1) must be in writing, (2) sent or given to the Health Information Management Department, 751 S. Bascom Ave., San Jose, CA 95128 and 3) is effective when it is received by the department. A cancellation will not apply to actions already taken by SCVHHS under this authorization or if the authorization was required for getting insurance coverage and the insurer has a legal right to contest a claim. Verbal cancellation will be accepted for behavioral health medical record pursuant to WIC Section 5328. Call: 408-885-5770.

9 CONDITIONS: I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on my giving or refusing to give this authorization except if my treatment is related to research, or if health care services are given to me only for creating protected health information for release to a third party. I also understand that I may refuse to sign this authorization.
A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

10

_____ _____ _____ _____
Patient/Patient's Representative Name Patient/Patient's Representative Signature Relationship Date

Department logo & contact can be inserted here. (VMC, PH, BH, Custody, VHP)

Attachment B: Santa Clara Valley Health & Hospital System Locations – To be updated and edited by the Department Custodian of Medical Record as applicable.

Valley Medical Center

- ☐ Valley Medical Center Hospital
- ☐ Valley Homeless Clinic
- ☐ Medical Respite Center
- ☐ Bill Wilson Drop-In Center Clinic
- ☐ Spark Clinic
- ☐ Valley Specialty Center
- ☐ Renal Care Center
- ☐ Valley Health Care Clinic - Milpitas
- ☐ Valley Health Care Clinic - Moorpark
- ☐ Valley Health Care Clinic - Sunnyvale
- ☐ Valley Health Care Clinic - Tully
- ☐ Valley Health Care Clinic - Downtown
- ☐ Valley Health Care Clinic - Milpitas
- ☐ Valley Health Care Clinic - Bascom
- ☐ Valley Health Care Clinic – East Valley
- ☐ Valley Health Care Clinic - Gilroy

Attachment C: How to fill out "Authorization for Use or Disclosure of Patient Health Information" form.

1 Requestor must complete this section. If not complete, form may be returned. Complete each box with the following information (print clearly):

- Patient's name.
- Patient's Date of Birth.
- ID or Medical Record Number.
- Home Address, including City, State and Zip Code.
- Telephone Number

2 Insert the department (VMC, VHP, Behavioral Health, Custody, or Public Health) under the "I give permission to" box. Then, write the name of the person or organization who is to receive the information.

- Name or Organization.
- Street Address, including City, State and Zip Code.
- Telephone/Fax Number of person who will receive information.

3 State the purpose for the release of information. Examples: Insurance application, Legal, Benefits, School, etc. ("For my own purposes" can only be used when releasing records to yourself).

4 Indicate what information may be released. Check the boxes that apply to your request and be specific:

- Specify type of information: medical records, HIV/AIDS test results, drug and alcohol treatment, and/or mental health records.
- Initial where indicated.
- If applicable, specify type of information such as x-ray, images, reports, or billing; or
- Specify clinic location where services were received. Refer to Attachment B for listed SCVHHS locations
- Specify date range of records being requested, if applicable.

5 Indicate how to receive the information: mail, pick up, or fax. If no method selected, default will be paper records for pick up.

6 Please indicate if you want paper, CD, films, or verbal release. If no method selected, default will be paper records for pick up.

7 List date authorization expires. If no date listed, authorization is valid for one (1) year.

8 Please read cancellation rights.

9 Please read conditions.

10 Print name, sign and date the authorization. Identify the relationship with the patient signs by patient's representative.

**There may be a fee associated with this request. Please contact the Custodian of Records to get a list of fees.