3ROI

Note: Fees may apply to certain requests

Use or Disclosure: I hereby authorize (*select appropriate JMH entity or location below*):

- ☐ Walnut Creek Medical Center ☐ Concord Medical Center
- ☐ Behavioral Health Center
- ☐ Physician Network Practice Office (specify practice location below):

_____

- ☐ Other (specify):_____

To release health information to:

_____

Name of person or facility to receive health information (full address):

_____

Street address:

_____

City, State, Zip Code:

_____

Email:_____

The purpose of this release is for (check one or more):

- ☐ Continuity of care or discharge planning
- ☐ Billing and payment of bill
- ☐ At the request of the patient/ patient representative
- ☐ Other (state reason) _____

_____

Limitations, if any: _____

_____

Additional Receiving Parties (Behavioral Requests Only):
Psychiatrist:_____ Therapist_____ PCP:_____ Other: _____

Requested Format: ☐ Paper (charges apply) ☐ CD (charges apply) ☐ Encrypted Email ☐ Other (specify):_____

Delivery Preference: ☐ Mail ☐ Pickup ☐ Encrypted Email ☐ MyChart Patient Portal ☐ Other:_____

Please specify the health information you authorize to be released.

☐ Hospital Records ☐ Outpatient Records ☐ Imaging Reports ☐ Imaging Films ☐ Lab
☐ Procedure/Operative Reports ☐ Billing ☐ Immunizations ☐ Other: _____
Date(s) of treatment: _____

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

- ☐ _____ (initial) Information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. Part 2).
- ☐ _____ (initial) Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §5328, *et seq.*)
- ☐ _____ (initial) Release of HIV test results (Health and Safety Code §120980(g)).
- ☐ _____ (initial) Release of genetic testing information (Health and Safety Code §124980(j)).

Expiration: This authorization expires on (date):_____. If blank, authorization will expire in 1 year from date of signature.

Signature:_____ **Date:** _____ **Time:** ____ **Phone:** _____

Print Patient Name: _____ **Date of Birth:** _____

Print Requestor Name (if other than patient, documentation may be required): _____

Relationship to Patient: ☐ Legal Representative ☐ Spouse
☐ Parent (Minor consent may be required) ☐ Guardian ☐ Conservator ☐ Beneficiary

RELS-36 (4/29/21)

ID VERIFICATION (TYPE)

ID VERIFIED BY

PATIENT LABEL

PRINT NAME:

DOB:

MRI:

JOHN MUIR HEALTH

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

WHITE - CHART YELLOW - PATIENT

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.