2ROI

Completion of this document authorizes the disclosure and / or use of health information, about you. Failure to provide *all* information requested may invalidate the Authorization. *Mail the completed form to:*
Washington Township Medical Foundation 39300 Civic Center Dr., Suite 370 Fremont CA 94538. Fax 510-608-6055

Patient name: _____

Date of Birth: _____ Date(s) of Treatment: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

☐ I hereby authorize Washington Township Medical Foundation to release to:

☐ I hereby authorize _____ to release to:

Name of Agency / Facility / Person:_____

Address: _____

City, State, Zip Code:_____

Telephone Number: (_____) _____ FAX: (_____) _____
the following information:

a. ☐ Disch Summary ☐ History & Physical ☐ Operative / Proc Report
☐ Pertinent Info Packet ☐ Complete Medical Record
☐ Other _____

b. I specifically authorize release of the following information (check if applicable):
_____ Mental Health Treatment Information
_____ HIV Test Results
_____ Alcohol / Drug Treatment Information

PURPOSE

Purpose of requested use or disclosure:
☐ Attorney / Legal ☐ Continuing Medical Care ☐ Insurance
☐ Patient Access ☐ Other _____

Office Use Only
☐ Faxed
☐ Mailed
☐ Picked Up
Date _____

3170 MRA 441 (4/6/17)

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Washington Township Medical Foundation
Part of Washington Hospital Healthcare System

EXPIRATION

This Authorization expires 30 days from the date this authorization is signed.

MY RIGHTS

I may inspect or obtain a copy of my requested health information and understand I will be charged a fee of *up to .25¢ per page.*

I may revoke this Authorization at any time, but I must do so in writing and submit it to Washington Hospital Healthcare System — HIM Department 2000 Mowry Avenue, Fremont, CA 94538.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of the Authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure may no longer be protected by state or federal confidentiality laws. However, California law prohibits the re-disclosure of medical information without obtaining a new authorization or unless otherwise required by law.

SIGNATURE

Date: _____ Time: _____am / pm

Signature: _____

(Patient / representative / spouse / financially responsible party)

Printed name: _____

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

_____

Witness:_____