PLEASANTON
DIAGNOSTIC IMAGING CENTER

4211 Rosewood Drive, Suite 5
Pleasanton, CA 94588

Health Information Department - Phone Number (925) 467-1400 - Fax Number (925) 467-1409

AUTHORIZATION TO USE AND DISCLOSE HOSPITAL HEALTH INFORMATION

Medical Record Number:___________________

Patient's Name: ____

Last **First** **Middle**

Home Address: ____

City/State/Zip ____

Home Telephone: _________________________________ Date of Birth: ___________________________

SPECIFY INFORMATION TO BE DISCLOSED: **The information that may be disclosed under this Authorization includes:** ____

____.

MY HIGHLY CONFIDENTIAL INFORMATION**: Only If It Applies.**

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about mental health or mental retardation services
☐ Psychotherapy Notes created by a mental health professional
☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ Information about sexually transmitted diseases
☐ Information about alcohol or drug abuse treatment program services
☐ Information about sexual assault
☐ Information about child abuse and neglect

RECIPIENT: **Name of person or class of persons to whom Pleasanton Diagnostic Imaging may disclose my health information:** ____.

Address of the recipient or where my health information should be delivered: _______________________________

____.

TERM: **This Authorization will remain in effect:**

☐ **From the date of this Authorization until the ___________ day of _______, 201___.**

☐ **Until Pleasanton Diagnostic Imaging has this request.**

☐ **Until the following event occurs:** ____.

☐ **Other:** ____.

PURPOSE: I authorize Pleasanton Diagnostic Imaging to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): [Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization]_____________

____
____________________.

I understand that once [Insert Facility] discloses my health information to the recipient, [Insert Facility] cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that [Insert Facility] may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at [Insert Facility] ; except, however, if my treatment at [Insert Facility] is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case [Insert Facility] may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to [Insert Facility's] Privacy Office at the address listed below. The revocation will be effective immediately upon [Insert Facility]'s receipt of my written notice, except that the revocation will not have any effect on any action taken by [Insert Facility] in reliance on this Authorization before it received my written notice of revocation.

I may contact [Insert Facility's] - Privacy Office by mail at [Insert Facility Address] OR by telephone at [Insert Facility Telephone Number]or by e-mail at [Insert Facility E-mail].

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize [Insert Facility] to use or disclose my health information in the manner described above.

______________________________	____________________
Signature of Patient	**Date**

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

____________________	____________________	____________________
Signature of Authorized Personal Representative	Relationship to Patient	Date

Revised 10/13/11