Yosemite Medical Clinic
Yosemite Emergency Medical Services

9000 Ahwahnee Drive PO Box 550 | Yosemite National Park, CA 95389 | Phone: (209) 372-4637 | Fax: (209) 372-4330 | yose_ymc@nps.gov

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please review and complete this form carefully. It may be determined to be invalid if not fully completed.

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Last 4 of Social Security #:_____
(If Applicable) (Optional)

Seen and/or treated by: ☐ **Yosemite Medical Clinic** ☐ **Yosemite Emergency Medical Services** ☐ **Both**
(Ambulance)

OR

☐ **Provider:**_____
(Provider Name, and Address/Telephone/Fax Number if known)

1. I authorize the use and/or disclosure of my protected health information described below (please check box(es) that apply, and provide any additional information you wish):

☐ All Medical (Clinic/Hospital) Records ☐ All Ambulance Records ☐ Laboratory Reports ☐ Pathology

☐ Ambulance Billing Information ☐ Clinic Billing Information ☐ Imaging Reports (X-Ray) ☐ History and Physical

☐ Medication Records ☐ Discharge Summary ☐ Test Reports (specify:_____)

☐ Other- please describe:_____

2. Authorization for Sensitive Information: If my records contain any of the types of information listed below I authorize the disclosure of that information <u>ONLY if I place my INTIALS</u> next to the type of information:

_____HIV (AIDS virus) or other sexually transmitted diseases _____Genetic Information

_____Mental illness and/or psychiatric treatment _____Drug and/or alcohol abuse

3. This authorization of the use and/or disclosure of the information described above covers the following dates:

☐ All Dates OR ☐ Only from _____/____/_____ through _____/_____/_____
mo day year mo day year

4. The purpose(s) I am authorizing this use or disclosure (check all that apply):

□ At My Request (If you check this box, no other box need be checked)

□ Continued Medical Care □ School □ Personal use □ Insurance Claim

□ Social Security/Disability Determination □ Insurance Application □ Legal Matter

□ Other – please describe the other purpose(s):_____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please review and complete this form carefully. It may be determined to be invalid if not fully completed.

5. I authorize _____ to release health information to:
Name of person or facility, which has the health information

Name of person or facility to receive the health information

Specify name/title of person to receive the health information, if known

Street Address, City, State, Zip Code

( ) _____ ( ) _____ _____

Telephone Number Ext Fax Number Email

I prefer records be sent by: □ Mail □ Fax □ Electronically by Secure File Transfer, if available.
US Mail will be used if other methods are not available.

6. Expiration Date or Event of this Authorization: This authorization shall be valid - unless I revoke it earlier in writing - until: (please check one)

☐ One year from the date I sign this authorization ☐ The following date: _____/_____/_____

☐ When the following event occurs: _____

NOTE: If this authorization is given by a parent or legal guardian on behalf of a minor, it will expire on the minor's eighteenth birthday.

7. I understand that:

a. I may revoke this authorization at any time in writing by providing written notice to the person(s) or class of persons I am authorizing to make this use and disclosure. Yosemite Medical Clinic / Yosemite Emergency Medical Services will furnish me with a form to make my written revocation if I ask for the form but I am not required to use that form. My revocation will not apply to the information already used or disclosed at my request by this authorization.
b. I will be able to receive any treatment or benefits I am entitled to whether or not I sign this authorization as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.
c. When my information is used and/or disclosed as requested by this authorization, it may no longer be protected by federal health information privacy law and may be subject to re-disclosure by the recipient(s).
d. This does not authorize use or disclosure of psychotherapy notes, sale of protected health information or uses and disclosures for marketing purposes.

8. Signature: By signing this authorization for use and disclosure of protected health information I certify that I make this authorization voluntarily and understand that I am entitled to a copy upon request.

X_____ _____/_____/_____

Signature of □ Patient or □ Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative (if any) Personal Representative's Authority to Act for the Patient (e.g., Parent, Guardian, etc.)
(Documentation may be requested)

FOR OFFICE USE ONLY

Date form received _____/_____/_____ □ Identity of Patient verified □ Identity & Authority to Act of Personal Rep. verified, if applicable.
Authorization determined to be □ VALID □ INVALID by:

_____ _____ _____/_____/_____

Signature Printed Name/ Title Date

Comments:_____