Cottage Health
GOLETA VALLEY | SANTA BARBARA | SANTA YNEZ VALLEY

2ROI

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

This document authorizes disclosure of individually identifiable health information required by State and Federal law. You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain services from Cottage Health (CH).

Failure to provide all information requested may invalidate this Authorization.

A. PATIENT INFORMATION:

Patient Name (please print):_____

Date of Birth: _____ SS# (optional): _____ Other names:_____

B. ABOUT THE HEALTH INFORMATION:

I request and authorize the release of health information on the above named patient for health care services provided by:

☐ Santa Barbara Cottage Hospital ☐ Goleta Valley Cottage Hospital
☐ Santa Ynez Valley Cottage Hospital ☐ Cottage Rehabilitation Hospital
☐ Other: _____

Please note: Mental Health/Chemical Dependency and HIV results are protected by special confidentiality laws that require you specify if this data is to be included in this disclosure. Please indicate if you want the specific information noted to be included:

☐ *Mental Health ☐ Chemical Dependency ☐ HIV

*California State Law requires we obtain written permission from the Attending Physician

Date(s) of visit or care (please be specific): _____

Type of visit or care (i.e., E.D., Inpatient, Outpatient, surgery etc.): _____

Specific health information to be released (refer to medical record content list):

☐ Visit Summary ☐ Continuation of Care ☐ Surgical ☐ Diagnostic
☐ Other (please specify):_____

List any restrictions or limitations (if any): _____

I understand that this information will be used for the following purpose (i.e. follow-up with physician, attorney, insurance, personal files, etc.): _____

C. TO WHOM INFORMATION SHOULD BE GIVEN:

I authorize that this information be disclosed to: Name: _____

Title / Position / Relationship to Patient : _____

_____(___)(___)-(_____)

(Street address) (City) (Zip) (Telephone)

D. DELIVERY METHOD: (if by mail, copies will be sent to address listed in section C)

☐ MAIL ☐ PICK UP ☐ PORTAL (patient only) email address:_____

E. EXPIRATION:

This authorization is effective now and will remain in effect until (insert date):_____.

F. YOUR RIGHTS:

- You have a right to receive a copy of this Authorization. If you need to have a copy mailed to you, please provide complete mailing address where you wish to have the copy sent:

Address: _____ State: _____ Zip: _____

Copy provided: ☐ Yes ☐ No Comment(s): _____

- You have a right to revoke (withdraw) this authorization at any time by submitting a signed written request to: Health Information Management, Santa Barbara Cottage Hospital (see address below). Your revocation will be effective upon receipt, but will not be effective to the extent that actions to comply with the original request have already been taken, or if the authorization was obtained as a condition of obtaining insurance coverage.

G. RESTRICTIONS:

The recipient of medical information disclosed pursuant to this authorization should not further disclose the information provided based on this authorization except in accordance with a new authorization or as specifically required or permitted by law. However, once released, the information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law.

H. COST & TIME:

Cost: There may be a fee for copies of medical records. You will be notified in advance if there are any fees incurred. This fee is waived for copies of health information sent directly to a health care provider. Copies are usually available within 15 days after a valid request is received.

I. **AUTHORIZING SIGNATURE: (ELECTRONIC SIGNATURE NOT VALID)**

Signature: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate relationship. Legal proof validating authority will be required before this request can be honored:

☐ Parent or guardian of minor patient (to the extent minor could not have consented to care)

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of a deceased patient

Validation Section for CHS Staff Use:			
Date/Time Received:	Staff Initials:		Complete when applicable:
Received by:		MRN/Encounter	
Requestor ID verified by:		Verification document:	
Authority to access verified by:		Verification document(s):	

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