Cottage Health

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: _____ 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
- ☐ Santa Ynez Valley Cottage Hospital
- ☐ Pacific Diagnostic Labs (PDL)
- ☐ Goleta Valley Cottage Hospital
- ☐ Cottage Rehabilitation Hospital
- ☐ Cottage Urgent Care
- ☐ Other: _____

Please note: Mental Health/Chemical Dependency, Reproductive Healthcare, 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 ☐ **Reproductive Healthcare

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

**Defined as "Health care that affects the health of an individual in all matters relating to the reproductive system and its functions and processes."

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

Health information to be released: ☐ Emergency Dept. Record ☐ Provider (Physician) Notes

☐ Diagnostic Test Results (Labs, Radiology Reports, Etc.) ☐ Operative/Procedure Report(s)

☐ Radiology Images ☐ Billing ☐ Other (please specify): _____

This information will be used for the following purpose(s): ☐Continuation of Care

☐ Insurance ☐ Legal ☐ Personal files ☐ Other: _____

C. TO WHOM INFORMATION SHOULD BE GIVEN:

I authorize this information be disclosed to: ☐ Patient (self)

☐ Other, Name: _____

Relationship: _____

Recipient contact number: (_____)_____-_____

D. DELIVERY METHOD (select one): ☐ MyChart ☐ Pick-up (appointment only)

☐ **E-mail**: _____ ☐ **Fax:**(_____)_____-_____

☐ **Mail:** _____

(Street address) (City) (Zip)

E. EXPIRATION:
This authorization is effective now and will remain in effect until (insert date): _____
If no date is indicated, this Authorization will expire 12 months after the date of signing this form.

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).

G. RESTRICTIONS:
The recipient of the protected health information is prohibited from redisclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by 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: (VALID ELECTRONIC SIGNATURES WILL BE ACCEPTED)

Signature: _____ Date:_____

Print Name:_____

Requester contact number (if different than recipient): (_____)_____-_____

If not signed by the patient, please indicate relationship:_____

Legal documents 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

❖ **Submit completed form to Health Information Management via any method below:**

E-MAIL: medicalrecords@sbch.org **FAX:** (805) 749-2879

MAIL: Cottage Health, H.I.M. Dept., P.O. Box 689, Santa Barbara, CA 93102

If you have questions, please call 805-352-2506