R O I M R

Patient name:	DOB:	MR# *(office use only)*:

I authorize _____ to release PHI to:
(name of person/facility which has information)

_____
*(name of person/facility to **RECEIVE** PHI)*

Address:_____

City/State/Zip Code:_____

Phone:_____ Email:_____

I request to receive my copies:	☐ Patient pick-up	☐ Paper copy
☐ Thumb drive	☐ Fax (phone: _____)	☐ Mail to above address

SPECIFY HEALTHCARE FACILITY FROM WHICH PHI IS REQUESTED:
☐ Hospital, 300 Canal Street, King City, CA 93930 (831) 385-7183 Fax (831) 385-0366
☐ King City Clinic, 210 Canal Street, King City, CA 93930 (831)385-7100 Fax (831) 385-5940
☐ ADOC Greenfield, 467 El Camino Real, Greenfield, CA 93927 (831) 674—0112 Fax (831) 674-4199
☐ Specialty Clinic, 400 Canal Street, Suite B., King City, CA 93930, (831) 386-7401 Fax (831) 386-7402
☐ Adult Medical Clinic, 400 Canal Street, Suite C., King City, CA 93930 (831) 385-7200 Fax (831) 385-5940
☐ Rehabilitation Services, 809 Broadway Street, Suite C., King City, CA 93930 (831) 385-6835 Fax (831) 385-6686
☐ Family Medical Center, please contact Health Information Management (831) 385-7235 Fax (831) 385-0366
☐ Children's Health and Wellness Center, 809 Broadway Street, Suite D, King City, CA 93930 (831)386-7437 Fax (831) 386-7312

INFORMATION TO BE RELEASED: Specify date or time period for the information selected below:		
☐ Billing statements	☐ Laboratory reports	☐ Drug and Alcohol abuse information
☐ Consultations/Evaluations	☐ Operative reports	☐ Genetic testing information
☐ Discharge Summary	☐ Outpatient clinic records	☐ HIV/AIDS test results
☐ EKG	☐ Pathology reports	☐ Mental Health (other than psychotherapy notes)
☐ Emergency reports	☐ Progress notes	☐ Other:_____
☐ History and Physical Exam	☐ Radiology/X-rays REPORT or FILMS *(circle one)*	

Mee Memorial Healthcare System
300 Canal Street • King City, CA 93930
(831) 385-6000

Authorization for Use and Disclosure of (PHI) Protected Health Information
8700.004 (Rev. 7/17/24 – FINAL)

Patient name:	DOB:	MR# *(office use only)*:

THE PURPOSE OF THIS RELEASE IS *(check one or more)*:

☐ At the request of the patient/patient representative

☐ Other *(state reason)*:_____

Initials of Patient or Legal Representative:_____

NOTICE: Mee Memorial Healthcare System and many other organizations and individuals, such as physicians, hospitals, and health plans, are required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality law.

MY RIGHTS:

- I understand this authorization in voluntary. Treatment, payment and enrollment, or eligibility for benefits may not be conditioned on signing this authorization except if the authorizations is for:
  1. Conducting research-related treatment,
  2. To obtain information in connection with eligibility or enrollment in a health plan,
  3. To determine an entity's obligation to pay a claim, or
  4. To create PHI to provide to a third party.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to Health Information Management, Mee Memorial Hospital and Clinics, 300 Canal Street, King City, CA 93930. The revocation will take effect when Mee Memorial Hospital and Clinics received it, except to the extent that Mee Memorial Hospital and Clinics or others have already relied on it.
- I am entitled to receive a copy of this authorization.

EXPIRATION OF AUTHORIZATION:

Unless otherwise revoked, this authorization expires _____ *(insert applicable date or event).* If no date is indicated, this authorization will expire **12 months** after the date of signing this form.

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Patient name:	DOB:	MR# *(office use only)*:
Signature:_____ *(patient)*		
Date:	**Time:** _____ **am / pm**	
If signed by a person **other** than the patient, indicate relationship:_____		
Print name:_____ *(legal representative)*		

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