Authorization to Release Medical Information to Individuals/Family Members

Community Memorial HEALTHCARE

In accordance with federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for physicians or staff of Community Memorial Healthcare Systems (CMHS), Centers for Family Health (CFH) to release your medical information, we must obtain your authorization prior to doing so. However, in the event of a critical episode, or if you are unable to give your authorization due to the severity of your condition, the law stipulates that these rules may be waived. Please indicate your preferences below.

Patient Name _____

Mailing Address _____

_____

Contact Phone _____

_____ I authorize CMHS CFH to send letters containing any or all of my medical information, including test results and recommendations, to the address provided above.

_____ I authorize CMHS CFH to leave messages on the voice mail at the phone number provided above.

_____ I authorize CMHS CFH to verbally release any or all information concerning my medical care to the following individual(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I understand that it is my responsibility to inform CMHS CFH promptly in writing of any changes I wish to make to this authorization. This authorization is to remain effective until _____ (not to exceed 24 months).

Signature of Patient or Guardian _____ Date _____
(not to exceed 24 months).

Witness _____

Community Memorial Urology

2705 Loma Vista Road, Suite #206, Ventura, CA 93003 | **O** 1-805-948-6041 | **F** 1-805-948-6841

JAN23 52897