San Buenaventura Urology Center

Community Memorial Health System

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with federal government privacy rule Implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for Physician 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 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 answering machine 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 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).

Patient Signature: _____ Date: _____

Witness: _____

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• *Adult & Pediatric Urology* •

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