KERN MEDICAL
1700 MOUNT VERNON AVE
BAKERSFIELD, CA 93306

Request made to/by:
☐ **Health Information Services Medical Legal**
Phone (661) 326-2591
Fax (661) 326-2593
☐ **Correctional Medicine**
Phone (661) 391-7913
Fax (661) 391-7386

AUTHORIZATION FOR USE AND / OR DISCLOSUREOF PROTECTED HEALTH INFORMATION

(Not To Be Used For The Release of Psychotherapy Notes***)***

Patient Name ____________________________________
(Last, First, Middle)
Address ____________________________________
City/State/Zip Code ____________________________________
Telephone Number ____________________________________
Date of Request ____________________________________

MR #/ACCT # ____________________
Date of Birth ____________________
Last 4 #'s of SS ____________________
Mother's Maiden Name/Other Name:
____

I authorize KERN MEDICAL to release information to:
Name of Provider Organization/Person : ____________________________________
Address: ____________________________________
Phone Number: ____________________________________ Fax Number: ________________

I authorize KERN MEDICAL to obtain information from:
Provider Name/Organization: ____________________________________
Address: ____________________________________
Phone Number: ____________________________________ Fax Number: ________________

Purpose of Request for Information: ☐ Healthcare ☐ Insurance Coverage ☐ Personal
☐ Other: ____________________________________

Information to be Released: ***(Check all applicable boxes and initial selection as required.)***
____(Initial) All my health information pertaining to any medical history, physical condition and treatment received. Or, only the following records or types of health information and/or only on the specified date(s):
Date(s) of Treatment: ____________________ Type of Treatment: ________________________
(*Inpatient, Emergency Dept, Outpatient, Other*)

☐ Discharge Summary
☐ History & Physical
☐ Operative Report
☐ Consultation
☐ Emergency Room Records
☐ Pathology Report
☐ Laboratory Reports
☐ Radiology Reports
☐ EKG Reports
☐ Physician Orders
☐ Medication Records
☐ Nursing Notes
☐ Radiology Film

__________ (Initial) Other: ____________________________________

__________ (Initial) Records of treatment for psychiatric or mental health illness

__________ (Initial) HIV test results or records of the diagnosis or treatment for HIV, HIV-related illness, AIDS, or AIDS-related.

I UNDERSTAND THAT:

- My right to healthcare is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the Medical Legal address provided on page 1 of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by the privacy regulations, the information stated above may be re-disclosed.
- A recipient of medical information in California may not further disclose medical information about me (patient) unless a new authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.

KERN MEDICAL contracts for the photocopying of patient records with a copy service company in accordance with the California Health and Safety Code and HIPAA regulations. Charging for the processing of photocopies of patient records is permitted and invoices will be sent directly to you from the contracted copy service. Charges for photocopies are $0.25 per page plus tax and postage when applicable.

AUTOMATIC ONE-YEAR DURATION. This authorization will automatically expire after one (1) year from date of execution unless a different end date or event is specified below.

End Date:______________________________ **or** Event Name: ________________________

____________________________________	____________________________
Signature of patient (or personal representative, if applicable)	Date
____________________________________	____________________________
Print name of personal representative (if applicable) (*Legal representative, parent, guardian, spouse)*	Relationship to patient *(If other than patient, describe relationship to patient.)*
____________________________________	____________________________
Address	Witness
____________________________________	____________________________
Phone No.	Type of ID presented. Attach copy.

COPY RECEIVED: I Acknowledge receipt of a signed copy of this authorization. _____Initials

<u>ATTENTION RECIPIENT</u>: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS <u>PROHIBITED</u> EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE.

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MEDICAL LEGAL PURPOSES ONLY:
Patient/Representative Identification Verified: Yes ___ No ___ Initials ____
Department_________
Records are to be: Mailed____________
or Picked up by Patient or Patient Representative_____________
or eDelivery ___________