Bakersfield Behavioral Healthcare Hospital

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION/
REQUEST FOR COPIES OF MEDICAL RECORDS

I (Patient Name) _____ Date of Birth _____

authorize **Bakersfield Behavioral Healthcare Hospital** to furnish copies of my medical records to:

(Name of person/organization) _____

Relationship to Patient _____ Address: _____

Phone no: _____Fax No.: _____ Email Address: _____

For the purpose of: _____

This information is limited to the following type and amount of information. (use dates where appropriate).

- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Physician Progress Notes
- ☐ Radiology Reports/Imaging Reports
- ☐ Consultation Reports
- ☐ Psychiatric Evaluation
- ☐ Laboratory Reports
- ☐ Other: _____

For Dates of Service: _____

NOTE: Records may include information related to alcohol or drug use and HIV or AIDS. However, treatment records from drug or alcohol facilities or results of HIV test will not be disclosed unless specifically requested.

I have a right to inspect and copy my medical records during business hours within 5 working days of making a written request (California Health and Safety Code (H&SC) §123110(a).
I understand that I have a right to obtain copies of my medical records within 15 working days of requesting it.
I understand that I do not have the right to access my psychotherapy notes which are notes taken by a mental health professional during an individual, group, joint, or family counseling session, and that are separated from the rest of my medical record. See 45 CFR 164.524(a)(1) – (a)(3) for a complete list of exceptions to the right of access.
I understand my provider may decline to give me access to my mental health records and that a written denial that includes the basis for the denial and how to file a complaint no later than 30 days after the request (no more than 60 days if the requester have been notified of an extension), See 45 CFR 164.524(b)(2). For a complete list of the grounds and conditions for denial of access, see 45 CFR 164.524(a)(2)-(4).
I have the right to revoke this authorization at any time.
I understand that my revocation must be in writing and presented to the Health Information Management Department.
I understand that the revocation will not apply to information that has already been released in response to this authorization.
I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
Unless otherwise revoked, this authorization will expire on the following date event or condition: _____.

If I fail to specify an expiration date, event or condition, this authorization will expire in six months. Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.
I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department.
I understand I have the right to receive copy of this authorization**.**

I wish to receive copies by:

☐ Mail (Address if different from above. No P.O. Box): _____

☐ Fax to: _____ Email Address (if different from above): _____

☐ I will pick up

Patient's Signature: _____ Date: _____

Name of Authorized Representative if Patient is unable to sign (Print): _____

Relationship to Patient: _____ Signature: _____ Date: _____

Name of Staff (print): _____ Title: _____

Signature: _____ Date: _____

Name of Physician: _____ Signature: _____ Date: _____