

**AUTHORIZATION FOR  
USE OR DISCLOSURE OF  
HEALTH INFORMATION**



**ENLOE**  
**MEDICAL CENTER**

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Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Health Record Number (*for hospital use only*): \_\_\_\_\_

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**I authorize the use or disclosure of the above named individual's health information as described below:**

1. The following individual or organization is authorized to make the disclosure:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

2. The type and amount of information to be used or disclosed is as follows:  
(include dates where appropriate)

\_\_\_\_\_ Most recent history and physical

\_\_\_\_\_ Most recent discharge summary

\_\_\_\_\_ Most recent operative/procedure reports

\_\_\_\_\_ Laboratory results from (date) \_\_\_\_\_ to (date) \_\_\_\_\_

\_\_\_\_\_ X-ray and imaging reports from (date) \_\_\_\_\_ to (date) \_\_\_\_\_

\_\_\_\_\_ Consultation reports from (doctors' names) \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_

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3. I understand that the information in my health record may include information relating to behavioral or mental health services, and treatment for alcohol and drug abuse, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), but that information will not be released unless specified in #2 (other).

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**Enloe Medical Center, Medical Records Department, Release of Information Office  
1531 Esplanade, Chico, CA 95926 • 530-332-5518 • Fax 530-893-6824**

4. This information may be sent to and used by the following individual or organization:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

For the purpose of: \_\_\_\_\_

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure 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 Medical Records Department, Release of Information Office located at 1531 Esplanade, Chico, CA 95926 or call them at 530-332-5518 or fax them at 530-893-6824.

\_\_\_\_\_  
**Signature of Patient or Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**If signed by Legal Representative,  
Relationship to Patient**

\_\_\_\_\_  
**Witness Signature**