

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 *et seq.*

AUTHORIZATION

I hereby authorize Marin General Hospital Other - Specify _____
to release my medical information, as described below, to:

Name: _____

Street Address: _____

City/State/Zip: _____

INFORMATION TO BE RELEASED

Patient Information: Name of Patient _____

Date(s) of Admission/Service _____ Date of Birth _____

Please initial the appropriate box(s) below or describe your request under "Other". X-Ray Films Available in Radiology Dept.

Discharge Summary Lab Results Emergency Room

Operative / Pathology Reports X-ray Reports EKG Reports

Other: _____

Psychiatric - I consent to the release of psychiatric diagnosis and treatment information protected by the California Welfare and Institutions Code Section 500 *et seq.*

HIV - I consent to the release of the results of the Human Immunodeficiency Virus antibody test and any other HIV testing, diagnosis and treatment information protected by the Health and Safety Code section 199.21.

USE AND RESTRICTIONS

The recipient may use the information for the following purpose: _____

The recipient may not further use or disclose the information unless other written authorization is obtained (except where specifically required or permitted by law).

Special instructions or restrictions: _____

DURATION

This authorization shall become effective immediately and shall remain in effect until ____/____/____

ADDITIONAL RIGHTS (See reverse for more information)

I further understand that I have a right to receive a copy of this authorization upon my request.
Copy requested and received: Yes No _____ initials

AUTHORIZING SIGNATURE

Signature of Patient, Parent or Guardian

Date of Signature

If signed by other than Patient, indicate relationship

Witness

24140 (6/7/10)



MARIN GENERAL HOSPITAL
250 BON AIR ROAD GREENBRAE, CA 94904
415-925-7000

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

PATIENT INFORMATION

Name: _____

Telephone: _____

FAX BACK TO: (415) 461-5649

MRN (HIM USE ONLY): - - - -