



General Authorization for Use or Disclosure of Protected Health Information

Patient Name (print name) _____

Patient's Date of Birth _____ Today's Date: _____

Authorization: I hereby authorize _____ to use or disclose information to:

Recipient _____

Address _____

Phone numbers, fax numbers, etc. _____

The recipient may use my Health Information only for the following purposes:

Information Requested: Hospital and Date(s) of service: _____

I authorize disclosure of the information described below (check all that apply):

Table with 3 columns and 5 rows of checkboxes for medical records, pathology reports, discharge summaries, etc.

Expiration: This authorization expires (enter date) _____.

Restrictions: California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required/permitted by law.

Your Rights:

- You may refuse to sign this authorization and your refusal will not affect your ability to obtain treatment or payment.
• You may revoke this authorization at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to this address: Eden Medical Center, Privacy Officer, 20103 Lake Chabot Road, Castro Valley, CA 94546.
• Your revocation will be effective upon receipt, but will have no impact on uses or disclosures made while your authorization was valid.
• You have a right to receive a copy of this authorization. If this box [] is checked, you requested and received a copy. Initials_____
• You may inspect and obtain a copy of the health information authorized for use or disclosure.
• If this box is checked [], EMC will receive compensation for the use or disclosure of your health information.

Your Signature:

Patient/ Representative Signature _____ Relationship to patient: _____

Proof of relationship to patient: _____ Verified by: _____

Verified by [] Photo ID [] Matching Signature [] Other _____