Healdsburg District Hospital
1375 University Avenue
Healdsburg, CA. 95448
Ph: 707-431-6470 Fax: 431-6575

Healdsburg Primary Care
1312 Prentice Drive
Healdsburg, CA 95448
Ph: 707-433-3383 Fax: 4337210

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient: ______________________________Date of Birth _______________

I hereby authorize the use and disclosure of protected health information about the above patient as follows:

A. Name of person, class of persons, or organization authorized to make the requested use or disclosure: _________________________________
B. Name of person, class of persons, or organization authorized to receive and use my protected health information: _____________________________________
   ____
   ____
C. Description of patient's protected health information to be used or disclosed:
   ____
   ____
   ____
D. Patient's protected health information is being used or disclosed for the following purpose(s): ____
   ____
   ____
   [Attach additional pages, if necessary]

I understand that I have the following rights with respect to this Authorization:

1. The recipient of the protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law.
2. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits.
3. Healdsburg District Hospital or Healdsburg Primary Care will provide me with a copy of this Authorization.
4. I may revoke this Authorization at any time mailing or personally delivering a signed, written notice of revocation to one or both of the above addresses. Such revocation will be effective upon receipt, except to the extent that the recipient has taken action in reliance on this Authorization.

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5. I am entitled to notice if Healdsburg District Hospital or Healdsburg Primary Care will use or disclose the protected health information for marketing and receive payment for the use or disclosure of my protected health information.

This Authorization will expire on: _________________

____
Signature of Patient/Personal Representative*

____
Personal Representative's Authority Act on Patient's Behalf

____
Printed Name

____
____
____
Address and Telephone Number of Patient/Personal Representative

____
Date

____
*The "Personal Representative" is any of the following:

- For an incompetent adult:
  - A conservator of the patient's person
  - An agent appointed by the patient under a power of attorney for health care.
- For a minor who does not have special legal authority to sign an authorization:
  - Parent
  - Guardian
  - Any other person *in loco parentis*
- Any other individual who has the legal authority to make health care decisions on the patient's behalf (e.g., person who is the next-of-kin to a resident in a skilled nursing facility; person legally obligated to financially support patient); or
- An executor or administrator of the patient's estate or any beneficiary who stands to inherit property from the patient, if the patient is deceased