TWIN CITIES COMMUNITY HOSPITAL
Health Information Management
1100 Las Tablas Rd. Suite 1427
Templeton, CA 93465

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
(Meets Cal. Civil Code §56.11 and 45 C.F.R.§164.508 Requirements)

Patient's Name: _____
Last First Middle

Address: _____City/State/Zip: _____

Home Telephone: _____ Date of Birth: _____

SPECIFY INFORMATION TO BE DISCLOSED: I authorize Twin Cities Community Hospital to disclose the following information under this Authorization:

Abstract (Face sheet, Discharge Summary, History & Physical, Consult, Operative Report)

ER report Test Results (lab, x-ray, cardiology, EKG) Surgical (OP/Path report)

☐ Other _____

DATE(S) OF TREATMENT: _____

MY HIGHLY CONFIDENTIAL INFORMATION:
I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box below, if any such information will be used or disclosed pursuant to this Authorization:

HIV test results (lab report) and/or any other documentation making specific reference to these results.

NAME OF PERSON RECEIVING INFORMATION: (separate request for each receiving party)

Name: _____ Phone No.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Twin Cities Community Hospital to use or disclose my health information in the manner described above.

Signature of Patient/Personal Representative**	Date
Personal Representative's Authority To Act on Patient's Behalf	Printed Name

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