KERN MEDICAL CENTER
1700 MOUNT VERNON AVE
BAKERSFIELD, CA 93306

Request made to/by:
☐ **Health Information Services**
Release of Information
Phone (661) 326-2591
Fax (661) 326-2593
☐ **Correctional Medicine**
Phone (661) 391-7913
Fax (661) 391-7386

AUTHORIZATION FOR USE AND / OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Not To Be Used For The Release of Psychotherapy Notes)***

Patient Name _____ MR #/ACCT # _____
(Last, First, Middle)
Address_____ Date of Birth _____
City/State/Zip Code _____ Last 4 #'s of SS _____
Telephone Number_____ Mother's Maiden Name/Other Name:
Date of Request_____ _____

I authorize KERN MEDICAL CENTER to release information to:

Name of Provider Organization/Person : _____
Address: _____
Phone Number: _____Fax Number: _____

I authorize KERN MEDICAL CENTER to obtain information from:

Provider Name/Organization: _____
Address: _____
Phone Number: _____Fax Number: _____

Purpose of Request for Information: ☐ Healthcare ☐ Insurance Coverage ☐ Personal
☐ Other: _____

Please be advised that any request from or on behalf of an attorney or company will be subject to different charges from those for patient requests.

Information to be Released: ***(Check all applicable boxes and initial selection as required.)***

____(Initial) All my health information pertaining to any medical history, physical condition and treatment received. Or, only the following records or types of health information and/or only on the specified date(s):

Date(s) of Treatment: _____ Type of Treatment: _____
(*Inpatient, Emergency Dept, Outpatient, Other*)

☐ Discharge Summary
☐ History & Physical
☐ Operative Report
☐ Consultation
☐ Emergency Room Records
☐ Pathology Report
☐ Laboratory Reports
☐ Radiology Reports
☐ EKG Reports
☐ Physician Orders
☐ Medication Records
☐ Nursing Notes
☐ Radiology Film

Initials:
_____ Other:_____
_____ Records of treatment for psychiatric or mental health illness
_____ HIV test results, diagnosis or treatment for HIV records, HIV-related illness, AIDS, or AIDS-related.
_____ Records of treatment for substance abuse treatment

The requested records are to be sent out of the State of California and contain information regarding the treatment of any abortion-related and/or transgender services. In order to complete this request, the patient or legal representative must acknowledge and provide their signature below.

_____ _____
Signature of patient/legal representative Date

I UNDERSTAND THAT:

- My right to healthcare is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the Medical Legal address provided on page 1 of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by the privacy regulations, the information stated above may be re-disclosed.
- A recipient of medical information in California may not further disclose medical information about me (patient) unless a new authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.

KERN MEDICAL CENTER contracts for the photocopying of patient records with a copy service company in accordance with the California Health and Safety Code and HIPAA regulations. Charging for the processing of photocopies of patient records is permitted and invoices will be sent directly to you from the contracted copy service. Charges for photocopies are $0.25 per page plus tax and postage when applicable.

☐ **I understand that a patient portal is available at no cost.**

Choose One:

☐ **I choose to accept access to the patient portal**

☐ **I choose not to accept access to the patient portal**

AUTOMATIC ONE-YEAR DURATION. This authorization will automatically expire after one (1) year from date of execution unless a different end date or event is specified below.

End Date:_____ **or** Event Name: _____

_____	_____
Signature of patient (or personal representative, if applicable)	Date
_____	_____
Print name of personal representative (if applicable) (*Legal representative, parent, guardian, spouse)*	Relationship to patient *(If other than patient, describe relationship to patient.)*
_____	_____
Address	Witness
_____	_____
Phone No.	Type of ID presented. Attach copy.

COPY RECEIVED: I acknowledge receipt of a signed copy of this authorization. _____Initials

ATTENTION RECIPIENT: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE.

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Hospital Staff PURPOSES ONLY:
Patient/Representative Identification Verified: Yes ___ No ___ Initials ____
Department_____
Records are to be: Mailed_____
or Picked up by Patient or Patient Representative_____
or eDelivery _____
Patient was offered portal access Initals _____