

**Authorization for Use and Disclosure of Protected Health Information (PHI)
Regional Medical Center of San Jose**

Patient Legal Name _____	Birthdate _____	Social Security No. _____
Address _____ Telephone No. _____		
City _____ State _____ Zip Code _____		
I hereby authorize Regional Medical Center of San Jose to disclose medical record information and/or protected health information of the patient listed above to:		

<i>Name / Title</i>		

<i>Address</i>		
Purpose: _____		
For treatment date: _____		
Type of Access Requested: <input type="checkbox"/> Copies of the record <input type="checkbox"/> Inspection of the record	<input type="checkbox"/> Abstract/Pertinent <input type="checkbox"/> Emergency Room <input type="checkbox"/> H & P <input type="checkbox"/> Consult Report <input type="checkbox"/> Operative Report <input type="checkbox"/> Rehab Services	Selected Portions of PHI: <input type="checkbox"/> Lab <input type="checkbox"/> Imaging/Radiology <input type="checkbox"/> Cardiac Studies <input type="checkbox"/> Face Sheet <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Medication Record <input type="checkbox"/> Progress Notes <input type="checkbox"/> Physician Orders <input type="checkbox"/> Entire Record <input type="checkbox"/> Other _____ _____
I acknowledge, and hereby consent to such, that the released information may _____ contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. <i>Initials</i>		
Expiration: This authorization shall expire upon this expiration Date or Event:		
I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it. The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected. Fees/charges will comply with all laws and regulations applicable to release of information. I have read the above and authorize the disclosure of the protected health information as stated.		
_____	_____	_____
Date	Signature of Patient/Parent/Patient Representative	Relationship to Patient

Address and telephone number of Requestor (if different from patient information)		