



**WOODLAND CLINIC'S  
AUTHORIZATION FOR USE OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this authorization.

**USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:**

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Other Names: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Medical Record or Account #: \_\_\_\_\_

(Facility use only)

**I AUTHORIZE :**

Woodland Clinic Medical Group  
1207 Fairchild Court  
Woodland CA 95695  
Dr: \_\_\_\_\_

Barba/Bringhurst, MD  
239 W. Court Street, Suite B  
Woodland CA 95695  
Dr: \_\_\_\_\_

Woodland Clinic - Davis  
2660 W. Covell Blvd.  
Davis CA 95616  
Dr: \_\_\_\_\_

TO DISCLOSE TO: \_\_\_\_\_  
(Persons/organizations authorized to *receive* the information)

at the following address: \_\_\_\_\_  
(street, city, state and zip code)

**THE FOLLOWING RECORDS**, specific types of health information, or records for the date(s) of treatment as specified:

**DATES OF SERVICE:** \_\_\_\_\_

Physician Notes

Laboratory Tests

Consultation Reports

Nurse Notes

Physical Exam

Operative Reports

X-ray Reports

Discharge summary

Other: \_\_\_\_\_

**THE FOLLOWING INFORMATION** contained in the records specified below (**Initial applicable lines and boxes below**):

\_\_\_\_ Mental health or developmental disability treatment records (excludes "psychotherapy notes")

\_\_\_\_ Substance abuse treatment records

\_\_\_\_ HIV test results (This authorizes disclosure of laboratory test results only.)

**Note that your records may include information concerning your HIV status even if you do not check this box.)**

**ALL RECORDS** regarding my treatment, hospitalization, and outpatient care.

*A separate authorization is required for the use or disclosure of psychotherapy notes or research health information.*

**PURPOSE:** The purpose and limitations (if any) of the requested use or disclosure is:

At the request of the patient or personal representative; **OR**

Other: \_\_\_\_\_

**EXPIRATION:** This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified: \_\_\_\_\_

(insert date)

**MY RIGHTS:**

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address **Woodland Healthcare, Release of Information Dept. 1207 Fairchild Ct., Woodland CA. 95695**. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

**SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Patient or personal representative)

\_\_\_\_\_  
Print name of personal representative

\_\_\_\_\_  
Relationship to patient

Patient/Representative Identification Verified. *Initials:* \_\_\_\_\_ *Dept:* \_\_\_\_\_

⇒ **PICTURED I.D. MUST BE PRESENTED** ⇐