Palo Alto Medical Foundation
Sutter Health

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____ MRN: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email (optional): _____

Type of Access Requested:
[ ] Paper Copy (to be faxed) [ ] Email (encrypted –see below)
[ ] Other (must be agreed upon by patient and provider): _____
(Note: If you would like us to send information over email unencrypted, this increases the risk that the information could be read by an unauthorized third party.)

Delivery Method Requested: [ ] FAX [ ] Email

Purpose of Requested Use or Disclosure:
[X] Medical surveillance/compliance

Authorization
I hereby authorize: Occupational Health Services at Stanford Hospital & Clinics and Lucile Packard Children's Hospital
291 Campus Drive, Stanford, CA 94305
FAX (650)–498-4919 (allow 2-3 working days to process)

To release my health information to:

[ ] Self via E-mail to **(SHC/LPCH addresses only** which belong to the authorizing person)
SHC/LPCH email address: _____
OR

[ ] PAMF Employee Health FAX 650-853-2022
[ ] PAMF Employee Health Email (secure) PaloAltoMDEH@PAMF.org
OR

[ ] Fax to the following number: _____

Information to be released: (Please check all that apply)
[ ] All vaccinations and titers as they relate to hospital medical surveillance
[ ] All tuberculosis screening examinations, including blood tests, skin tests and x-rays
[ ] Tuberculosis screening questionnaire (last one completed)
[ ] N95 Fit testing results
[ ] Respiratory Questionnaire
[ ] Other: _____

Specify date(s) of service for records requested: _____

I specifically authorize release of the following information:
[ ] HIV test results ___ (initial) [ ] Substance abuse ___ (initial)
[ ] Mental Health ___ (initial) [ ] Genetic testing ___ (initial)

EXPIRATION: This authorization shall become effective immediately and shall remain in effect for one year from the date signed unless a different date is specified here:
2030

RESTRICTIONS: California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

YOUR RIGHTS:

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address: Mary Spangler, Occupational health at SHD MC 5205.
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have a right to receive a copy of this authorization (required if authorization is requested for the provider's use or disclosure of health information).
- I may inspect and obtain a copy of the health information of which I am authorizing the use or disclosure.

If this box [ ] is checked the facility listed above will receive compensation for the use or disclosure of my health information.

SIGNATURE: _____ Date: _____ Time: _____
(Patient/Legal Representative)

If signed by other than patient, print name and relationship:
Name: _____ Relationship: _____

There may be fees incurred for this service.

Office Use Only Identification verified by (name):_____
Verified by (method): [ ] Photo ID [ ] Matching Signature [ ] Other _____