SAN FRANCISCO CYBERKNIFE

Revolutionizing cancer treatment. Restoring hope. Improving lives.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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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 Used: _____ Telephone: _____

Medical Record or Account#: _____
(Hospital Use Only)

I AUTHORIZE: _____

TO DISCLOSE TO: **San Francisco CyberKnife**

At the following address: **900 HYDE STREET, SAN FRANCISCO, CA 94109**

The following information contained in the medical records specified below (initial lines below)

_____ Mental health or developmental disability treatment records (excludes 'psychotherapy notes')

_____ Substance abuse treatment records.

_____ HIV test results (this authorizes disclosure of laboratory tests results only. Note that your records may include information concerning your HIV status even if you do not initial this line.)

THE FOLLOWING RECORDS, specific types of health information, or records for the date(s) of treatment as specified [check applicable box(es)]:

☐ Billing Records ☐ Emergency Room Reports ☐ Procedure Reports
☐ Consultation Reports ☐ History and Physical ☐ X-ray Reports
☐ Discharge Summary ☐ Laboratory Tests ☐ Pathology Slides

Date(s): _____

Other: _____

☐ **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.

San Francisco CyberKnife is a service of and located at St. Francis Memorial Hospital.

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 diferent end date is specified_____. My revocation will take effect upon receipt, except to the extent that others have acted.

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: San Francisco CyberKnife, 900 Hyde Street, San Francisco, CA 94109 in reliance upon 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 confidentially law (HIPPA). 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 Patient Representative)

_____ _____
(Print name of Patient Representative) (Relationship to Patient)

Patient/Patient Representative Identification Verified: *Initials:* _____ *Dept:* _____

Note: if the substance abuse treatment information is protected by federal confidentially rules (42 C.F.R., part 2) the following prohibition of re-disclosure statements must be provided to the recipient of the information:

The federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R., part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.