

## Guam Memorial Hospital Authority Aturidat Espetat Mimuriat Guahan



850 GOV. CARLOS CAMACHO ROAD OKA, TAMUNING, GUAM 96911 TEL: 647-2444 or 647-2330 FAX: (671) 649-0145

## AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

## **EXPLANATION**

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code section 56 et seq and to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule.

THE FOLLOWING INFORMATION MAY BE RELEASED (CHECK): Face Sheets, any work up on cardiac and pulmonary.  History and Physical	Name/Organization	Address		Phone No.
History and Physical   XRAY reports   Consultation   Operative Reports   Other, please Specify   Pathology Reports   Discharge Summary   Lab Reports   Other, please Specify   Fife following items (*) must be initialed to be included in the use and/or disclosure of other health information:  **HIV/AIDS related information and/or records   *Mental Health information and/or records   *Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and wind of information is to be disclosed.) Describe:    Consultation   Discharge Summary   Lab Reports   Other much and/or records   *Mental Health information and/or records   *Prug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and wind of information is to be disclosed.) Describe:    Consultation   Discharge   Discha	Medical records and information	pertaining to medical history, mental or p	hysical condition, or services	rendered, or treatment of:
History and Physical	Name of Patient	Date of Birth	Contact Numl	per
The following items (*) must be initialed to be included in the use and/or disclosure of other health information:  *HIV/AIDS related information and/or records	THE FOLLOWING INFORMAT  History and Physical  Emergency Room  Pathology Reports	<ul><li>□ XRAY reports</li><li>□ Consultation</li></ul>	Operative Reports	
DURATION: This authorization shall become effective immediately and shall remain in effect until (date):  RESTRICTIONS: I understand that the requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.  YOUR RIGHTS: I understand that I have the right to revoke this authorization in writing, signed by me or my legal representative and delivered to My revocation will be effective upon receipt, but will not be effective to the extent this organization has taken action in reliance upon this Authorization.  I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment). The may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy.  The provided Hamber of the companies	*HIV/AIDS related info *Drug/alcohol diagnosi kind of information is to be discle	ormation and/or records*N is, treatment or referral information (Federosed.) Describe:	Mental Health information and all regulations require a descr	d/or records iption of how much and wha
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