Guam Memorial Hospital Authority
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OKA, TAMUNING, GUAM 96911
TEL: 647-2444 or 647-2330
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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.

AUTHORIZATION: I hereby authorize the release of information to be furnished to:

_____ _____ _____
Name/Organization **Address** **Phone No.**

Medical records and information pertaining to medical history, mental or physical condition, or services rendered, or treatment of:

_____ _____ _____
Name of Patient **Date of Birth** Contact Number

THE FOLLOWING INFORMATION MAY BE RELEASED (CHECK): Face Sheets, any work up on cardiac and pulmonary.

☐ History and Physical ☐ XRAY reports
☐ Emergency Room ☐ Consultation ☐ Operative Reports
☐ Pathology Reports ☐ Discharge Summary ☐ Lab Reports ☐ Other, please Specify_____

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 _____ *Mental Health information and/or records
_____ *Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe: _____
_____

List specific dates of records to be released: _____

FOR THE PURPOSE OF ☐ Patient Care ☐ Insurance Claim ☐ Self ☐ Other

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 that 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). I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy.

I understand that I have a right to receive a copy of this authorization upon request. Copy requested: _____Yes _____No

Signature: _____
(Patient/Legal representative) Date Time

If signed by other than patient, indicate relationship: _____ Witness: _____