Guam Memorial Hospital Authority
Aturidåt Espetåt Mimuriåt Guåhan
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.

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):

☐ Facesheet	☐ XRAY reports	☐ Operative Reports	☐ Cardiac
☐ History and Physical	☐ Consultation	☐ Pathology Reports	☐ Pulmonary
☐ Emergency Room	☐ 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:
(if item is applicable. If NOT please check ☐ **N/A**)
☐ *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 until:_____
Not to exceed 6 months from the Date of Request

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:_____

For Completion by Medical Records Staff
Completed By:_____
Print Sign Date Time