AUTHORIZATION TO RELEASE HOSPITAL RECORD INFORMATION

Authorization with an original signature* of an officer of the hospital is required to release hospital confidential data to persons not associated with the hospital.

Please release hospital confidential data to:

NAME:____

ADDRESS:____

PHONE:____

SIGNATURE:____

Officer authorizing release of hospital confidential data:

NAME:____

TITLE:____

HOSPITAL:____

ADDRESS:____

PHONE:____

SIGNATURE:____

*A FAXed document does not satisfy the criteria for an original signature.

Please complete, sign, and mail to:

Department of Health Care Services
Disproportionate Share Hospital Unit
1501 Capitol Avenue, MS 4506
P.O. Box 997419
Sacramento, CA 95899-7419