AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION
1535 AIRPORT BLVD., NAPA, CA 94558
Phone: 707-253-4591 / Fax: 707-253-4832

Patient Name:_____
Last Name First Name M.I.

Date of Birth:_____/ _____/ _____ MR/SSN #:_____

I authorize:

☐ Queen of the Valley Hospital
1000 Trancas Street, Napa
(707) 252-4411

☐ St Helena Hospital
650 Sanitarium Road, Deer Park
(707) 963-3611

☐ Kaiser-Permanente Hospital
975 Sereno Drive, Vallejo
(707) 651-1359

☐ Other:
_____

_____

to release/disclose health information to:

Napa County Sheriff's Department
1535 Airport Blvd.
Napa, CA 94558

Napa County District Attorney's Office
1127 First St.
Napa, CA 94559

and to the following Duly Authorized Representative:

_____

for the purpose of a law enforcement investigation. This information may be used to prove or disprove guilt in a criminal or civil hearing.

The Purpose of this Release is for a Criminal Investigation

Information Requested (check all that apply):

☐ Pertinent Summary ☐ Emergency Record ☐ Clinic Records ☐ Immunizations
Other (List):

Date(s) of Treatment: From a_____ to_____ All dates of service

The following information WILL NOT BE RELEASED unless you specifically authorize it by checking the appropriate box(es) below:

☐ Information pertaining to drug and alcohol abuse, diagnosis or treatment
☐ Information pertaining to psychiatric diagnosis or treatment
☐ Information pertaining to HIV/AIDs status
☐ Information pertaining to genetic testing information

Expiration of Authorization:

Unless otherwise revoked, this authorization expires on _____ or 12 months after the date of my signing this form. I understand:

- This authorization may be revoked in writing at any time, except to the extent that Napa County Sheriff has already disclosed the information.
- I may refuse to sign this authorization. Treatment may not be withheld of conditioned on obtaining this authorization.
- If disclosure of this health information is to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected.
- I have a right to receive a copy of this authorization.

Release or transfer of the specified information to any person or entity not specified herein is prohibited. An additional written consent must be obtained for a proposed new use of the information or for its transfer to another person or entity.

_____ _____ _____
Signature Date Area Code and Phone Number

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