

**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