REQUEST AND AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

SECTION I: PATIENT INFORMATION

Patient Name: ____________________

Address: ____________________

City: ________ **State/Province:** ________ **Country:** ________ **Postal Code:** ________

Telephone Number: ____________________ **Date of Birth:** ____________________

SECTION II: INFORMATION TO BE DISCLOSED

By signing this Authorization, I voluntarily authorize **Hospital San José S.A.** (the "Hospital") to disclose the following information from my health record (Check all that apply):

- ☐ Only information related to (specify): ____________________
- ☐ Only the period of events from ____________ to ____________
- ☐ Complete medical record
- ☐ Other, i.e. x-rays, bills (specify dates): ________

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- ☐ Alcohol/drug abuse treatment/referral
- ☐ HIV/AIDS-related treatment
- ☐ Sexually transmitted diseases
- ☐ Mental health (other than psychotherapy notes)
- ☐ Psychotherapy notes ONLY (by checking this box, I am waiving any psychotherapy-patient privilege)

SECTION III: RECIPIENT AND PURPOSE

I authorize the Hospital to disclose the information from my health record to the following individual or company:

Name: ____________________ **Organization/Entity:** ____________________

Address: ____________________

City: ________ **State/Province:** ________ **Country:** ________ **Postal Code:** ________

Telephone Number: ____________________ **Email:** ____________________

I hereby release the Hospital and its personnel from any and all claims, demands, damages, causes of action, debts, liabilities, controversies, judgments, and suits of every kind and nature whatsoever, foreseen, unforeseen, known or unknown, that may arise out of such disclosure.

This protected health information is being used or disclosed for the following purpose:

- ☐ Transfer of records to another provider
- ☐ Transfer of records to complete health records at another entity
- ☐ Insurance claims information
- ☐ Personal use
- ☐ Other (describe) ____________________

I understand that I may revoke this authorization in writing at any time, by notifying the Hospital at Autopista Próspero Fernández, 600 meters east of Centro Comercial Multiplaza, Escazú, San José, Costa Rica, fax +506 2208.1001, or by email to legal@hospitalcima.com, except to the extent that action has been taken in reliance on this authorization. I further understand that the health record used or disclosed as a result of this authorization may be re-disclosed by the recipient and no longer be protected under privacy regulations. I also understand that I may refuse to sign this authorization, and if I do refuse, my ability to obtain treatment will not be affected. This Authorization shall expire ninety (90) days after the date below, unless I state a different expiration date here: ____________.

Finally, I understand that there are charges for photocopies of records and for records provided in English.

____________________ ____________________

Signature of Patient/Patient's Representative   Date

____________________ ____________________

Printed Name of Patient or Legal Representative   Relationship to Patient

If this Authorization has been signed by a patient's representative on behalf of an individual (for example, the parent or guardian of a minor, legal representative), supporting documentation granting his/her legal authority to act on behalf of the patient must be attached.

A copy of this signed Authorization must be provided to the individual completing this form.