

1. You may revoke this authorization at any time, but only in writing mailed to: Saint Agnes Medical Center c/o Health Information Management 1303 E. Herndon Ave. Fresno, CA 93720. Your Revocation will be effective upon receipt; only to the extent that Saint Agnes Medical Center has not already relied on this authorization.
2. You may receive a copy of this authorization.
3. Medical information released under this authorization may be subject to redisclosure by the recipient, and it may not be protected under state or federal information privacy laws.
4. This authorization will automatically expire 6 months after the date of signature below, excluding Patient Portal enrollment.
5. This authorization is not valid unless all required elements are completed.

I authorize Saint Agnes to release medical information as stated in this authorization:

Signature of Patient or Personal Representative

Date (Must be dated)

Printed Name of Patient Representative
(If not signed by the patient)

Authority to Act as Representative
(Documentation required)

**Return completed form to: Email: frhsmedicalrecords@samc.com
or Health Information Management 1303 E. Herndon Ave. Fresno, CA 93720**

Office Use Only

ID Verified

Released: _____ Department: _____ Date: _____

