**MEDICAL RECORDS DEPARTMENT**

**Telephone: (323) 583-1931 Ext. 6630; FAX: (213) 537-0964**

**AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION**

**EXPLANATION:** This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 et seq.

**PATIENT INFORMATION:**

|  |  |
| --- | --- |
| Patient Name: | Date of Birth: |
| Social Security #: | Cell #: |
| Address: | Home #: |
| City: State: Zip: | Work #: |

I hereby authorize **Community Hospital of Huntington Park** to use or disclose my individually identifiable information as described below. I understand that the information I authorize to a person or entity to receive my individually identifiable information may be re-disclosed and no longer protected by the federal privacy regulations.

|  |
| --- |
| **Dates of Hospitalization to be disclosed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**specific description of information to be disclosed (check only 1 Grey box):**

Pertinent Information: **(This is what most patients and physicians need)** Discharge Summary, History and Physical, Consultation Reports, Operative Reports, Labs, Radiology, EEG, EMG, EKG, Pathology Reports.

**OR**  My entire record **(Note: This may be very large).**

**OR**  Only the following records or types of health information **(Check all that apply):**

|  |  |  |
| --- | --- | --- |
| \_\_Emergency Room Record | \_\_Physician Orders | \_\_Nurses Notes |
| \_\_Operative Report | \_\_Discharge Summary | \_\_Lab Tests |
| \_\_History & Physical | \_\_Pathology Report | \_\_Physician Progress Notes |
| \_\_Consultation Reports | \_\_Radiology Report |  |
| \_\_Billing Record | \_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**AUTHORIZATION TO RELEASE STATUTORILY PROTECTED INFORMATION:**

I specifically authorize release of the following information **(Check and initial all that apply):**

|  |  |
| --- | --- |
| Mental health treatment information | Initial if requesting:\_\_\_\_\_\_ |
| HIV test results | Initial if requesting: \_\_\_\_\_\_ |
| Alcohol/drug treatment information | Initial if requesting: \_\_\_\_\_\_ |
| Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Initial if requesting: \_\_\_\_\_\_ |

**Purpose of requested use or disclosure:**

Patient Request  Continuing Care  Legal

Insurance  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONS OR ORGANIZATION AUTHORIZED TO RECEIVE INFORMATION:**

|  |  |
| --- | --- |
| Name/Facility: | Attention: |
| Address: | Phone #: |
| City: State: Zip: | FAX #: |

Mail Copy To: (Address Above)  Hold for Pick Up

Normally we send paper copies; check box if you would like a CD instead.

**INFORMED UNDERSTANDING:**

1. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or my ability to obtain treatment, except as provided in numbers 2 and 3 on this form.
2. If the purpose of this authorization is for an organization such as a health plan or life insurance company to determine eligibility before enrollment and the requested use or disclosure is not for psychotherapy notes, and I refuse to sign this authorization. The organization reserves the right to deny enrollment of eligibility for benefits.
3. If the purpose of this authorization is to disclose health information to another party based on healthcare that is provided solely to obtain such information, and I refuse to sign this authorization, the Hospital reserves the right to deny that healthcare.
4. I understand that I may inspect or receive a copy of the information used or disclosed.
5. I understand that I have a right to receive a copy of this authorization.
6. I understand that I may revoke this authorization at any time by notifying the Hospital in writing, except to the extent that:
   * Action (PHI already used or disclosed) has been taken in reliance of the authorization; or
   * If this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

**DURATION:**

This Authorization expires [insert date]: \_\_\_\_\_\_\_\_\_\_\_

If no Date is given; this authorization will expire 6 months from the signature date below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or patient's legal authorized representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of patient or patient's legal authorized representative

Authority: \_\_Guardian \_\_Conservator \_\_Medical Power of Attorney \_\_Parent, unemancipated minor

**If you are signing on behalf of a patient for whom you are the legal authorized representative, you must attach a certified copy of your appointment as a legal authorized representative.**