Canyon Ridge Hospital

5353 G. Street, Chino, CA 91710
(909) 590-3700 x2060 Fax: (909) 590-4038

AUTHORIZATION TO USE / DISCLOSE PROTECTED HEALTH INFORMATION

(A copy of this authorization will be considered as valid as the original)

I, the undersigned, authorize Canyon Ridge Hospital to release the following information:

Patient Name: _____ Date of Birth: _____

SS #: _____ Date(s) of Service: _____ - _____ Tel #: _____

Address: _____

Copies to: / Copies from:

Name/Organization: _____ Tel #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

I request this access as the:

☐ Patient ☐ Parent / Legal Guardian of Minor Patient ☐ Conservator of Patient

and I authorize copies of:

☐ Discharge Summary/Psychiatric Evaluation ☐ History & Physical Exam ☐ Laboratory Reports

☐ Other: _____

(subject to $0.25 per page charge)

The purpose for this disclosure is: _____

Your Rights

I understand that Canyon Ridge Hospital may charge a reasonable cost-based fee for the copying, preparing, mailing, and/or other supplies associated with my request for access of health information for personal use.

I understand the information in the health record relates to psychiatric / mental health services; it may also include information relating to AIDS or HIV, drug or alcohol abuse, and/or other abuse.

I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I may revoke this authorization at any time. My revocation must be in writing signed by me or on my behalf and delivered to Canyon Ridge Hospital, ATTN: Medical Records, 5353 G. Street, Chino, CA 91710. This authorization expires in 90 days from date below or _____

My revocation will be effective upon receipt, but will not be effective to the extent that the Hospital or others have acted in reliance upon this Authorization.

The recipient of the protected health information may not disclose the information unless the recipient obtains another authorization or unless the disclosure is specifically required or permitted by law.

I have a right to receive a copy of this authorization.

_____ _____ | _____

Patient Signature Printed Name

_____ _____ | _____

Parent / Guardian / Legal Representative Signature Printed Name Relationship to Patient

Date: _____ ***(required)*** Witness: _____