Canyon Ridge Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please read this authorization before you sign. Please PRINT

Completion of this document authorizes the release of protected health information that is consistent with the California and Federal law. **Failure to provide *all* information requested may invalidate this Authorization.**

USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: ______________________ Social Security #: ______________

Date of Birth: ____________ Dates of Service Being Requested: ______________

I, ________________________ authorize Canyon Ridge Hospital to release my Protected health information.

PERSON / ORGANIZATION AUTHORIZED TO RECEIVE AND USE MY PROTECTED HEALTH INFORMATION:

____

Name of Organization *Street Address* *City / State / Zip*

Purpose or need for this information ______________________________

____

Type of Protected Health Information to be released:

- ❑ Discharge Summary
- ❑ Laboratory Tests
- ❑ Progress Notes
- ❑ Complete Record
- ❑ Psychiatric Evaluation
- ❑ Radiology
- ❑ Billing Information
- ❑ History & Physical
- ❑ Medication Sheets
- ❑ Other ____________

EXPIRATION

I understand that this authorization shall become effective immediately and shall remain in effect until (date) ____________________ (six months from date of signature).

NOTICE OF RIGHTS AND INFORMATION

I understand that I have the following rights with respect to 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 may refuse to sign this Authorization as a condition to obtaining treatment or payment or any eligibility benefits.

I have the right to receive a copy of this authorization

I may revoke this Authorization at any time by mailing or personally delivering a signed, written notice of revocation to: the ***Privacy Officer, 5353 G Street, Chino, CA 91710***. The revocation will be effective upon receipt except to the extent that the recipient has taken action in reliance on this Authorization.

I understand that I am entitled to notice if Canyon Ridge Hospital will use or disclose the protected health information for marketing and receive payment for the use or disclosure of my protected health information.

Canyon Ridge Hospital ☐ Will ☑ Will not receive compensation for the use or disclosure of my protected health information.

I also agree to any fees associated with copying, reviewing and mailing the above records.

SIGNATURE

Signature of Patient / Personal Representative	Describe Personal Representative's Relationship to Patient and Authority to Act on Behalf of Patient
Printed Name	Date
	Witness
Address and Telephone Number of Patient / Personal Representative	