626-397-3370 PHONE

626-397-7185 FAX

Huntington Hospital

MR #: _____

AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION

Patient Name: _____
Last First Middle

Home Address: _____
Street

_____
City State Zip

Home Telephone: _____ DOB: _____

RECIPIENT: Name of person or class of persons to whom Huntington Hospital may disclose my health information: PLEASE CIRCLE ONE

Attorney Doctor DPA Insurance Self Other: _____

ADDRESS: Address of the recipient or where my health information should be delivered:

_____
Street

_____
City State Zip

I would prefer to:
- ☐ Pick-up or view the Requested Information
  OR
- ☐ Have the Requested Information mailed

TERM: **This Authorization will expire on:**

- ☐ The _____ day of _____, 20_____.
- ☐ If no date specified it will expire 6 months from the date signed.

Specify date(s) of service requested or event:

_____

Huntington Hospital

Please check appropriate box(s) Pertinent, All records or specific report(s) and / or test(s)

☐ Pertinent Records - Package A

☐ Face Sheet	☐ Consultation Reports	☐ Laboratory Tests
☐ Discharge Summary	☐ Operation Reports	☐ Radiology Reports
☐ ER Report	☐ Pathology Reports	☐ Cardiology Reports
☐ History and Physical		

☐ All Records -Package A and Package B

☐ Progress Notes	☐ Medications	☐ Rhythm Strips
☐ Physician Orders	☐ Special test/therapy	☐ Labor/Delivery summary
☐ Graphics	☐ Nurses Notes	

Highly Confidential PHI (Will not be released without specific consent)

By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this authorization:

- ☐ Mental Illness: _____
- ☐ Developmental Disability: _____
- ☐ Psychotherapy Notes: _____
- ☐ Communicable Disease: _____
- ☐ Sexual Assault: _____
- ☐ Child Abuse or Neglect: _____
- ☐ Genetic Testing: _____
- ☐ DomesticAbuse: _____
- ☐ Child Abuse or Neglect: _____
- ☐ Adult Abuse: _____
- ☐ Substance Abuse: _____
  (Prevention or Treatment)
- ☐ HIV/AIDS: _____
  (Testing, Diagnosis, or Treatment (regardless of result))

PURPOSE: I authorize Huntington Hospital to use or disclose my health information (including the highly confidential I selected above, if any) during the term of this Authorization for the following specific purpose(s): Note: **"at the request of the Patient"** is sufficient if the Patient is initiating this Authorization:

_____

Huntington Hospital

I understand that once Huntington Hospital discloses my health information to the recipient, Huntington Hospital cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable law governing the use and disclosure of my health information.

I understand that I may at any time make a written request to Huntington Hospital to inspect and/or obtain a copy of my health information, and that Huntington Hospital will either, within five days for a request to inspect and fifteen days for a request to copy, grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Huntington Hospital; except, however, if my treatment at Huntington Hospital is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Huntington Hospital may refuse to treat me if I do.

I understand that, at any time during which this Authorization is in effect, I may make a written request to receive a copy of this Authorization. Such written request shall be made to Huntington Hospital at the address listed below.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Huntington Hospital at the address listed below. The revocation will be effective immediately upon Huntington Hospital's receipt of my written notice, except that the revocation will not have any effect on any action taken by Huntington Hospital in reliance on this Authorization before it received my written notice of revocation.

I may contact Huntington Hospital's Medical Records Director

By mail: 100 W. California Blvd., Pasadena, CA 91109

By telephone: 626.397.8798

By email: cynthia.gillette@huntingtonhospital.com

Huntington Hospital

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Huntington Hospital to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient Date

If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Personal Representative: _____

Description of Authority: _____

Date: _____

For Internal Use Only: The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records.

_____

Signature of employee validating identity Date