

**AUTHORIZATION FOR USE
OF/OR DISCLOSURE OF
MEDICAL INFORMATION**

I authorize the following to be released:

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Emergency Department Visit | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> PT/OT |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Lab Report | <input type="checkbox"/> Spine Center |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Blood Type | <input type="checkbox"/> Home Health |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> X-Ray Report | <input type="checkbox"/> Hospice |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> X-Ray Films | <input type="checkbox"/> A Day Away |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> EKG Report | <input type="checkbox"/> Clinic |
| <input type="checkbox"/> Anesthesia Record | <input type="checkbox"/> Newborn Record | <input type="checkbox"/> |
| <input type="checkbox"/> Other, please specify: _____ | | |
| <input type="checkbox"/> EXCEPTIONS, please specify: _____ | | |

EXPIRATION

This authorization shall remain valid for one year from the date of signature unless specified by the following date: _____

RESTRICTIONS

California law prohibits the requestor from making further disclosure of my health information unless the requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS

I may refuse to sign this authorization.

I may revoke this authorization at any time. If I choose to revoke my request, I understand that my request must be placed in writing, and must be signed by me, or my legal representative and delivered to the following address:

***Presbyterian Intercommunity Hospital
Health Information Management Department
12401 Washington Boulevard
Whittier, CA 90602***

My revocation will be effective upon receipt, but will not be effective to the extent that the organization has taken actions in reliance upon this authorization.

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ADDITIONAL COPIES

I further understand that I have the right to receive a copy of this authorization upon my request.

Copy requested and received:

YES - NO Initial: _____

IF REQUESTOR SEEKS THIS AUTHORIZATION

I may inspect or obtain a copy of the health information that I am authorizing for use or disclosure.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

If this box is checked, the Requestor will receive compensation for the use or disclosure of my information. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE

Date: _____ Time: _____ AM/PM

Signature: _____
[patient/legal representative]

If signed by someone other than the patient, state your legal relationship to the patient.

Relationship: _____

Witness: _____

(If you have authorized the disclosure of your health information to someone, who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from re-disclosing such information except with your written authorization or as specifically required or permitted by law)