PROVIDENCE
Saint Joseph
Medical Center

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Burbank, CA 91505
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Office: 818-847-3801

IMPORTANT - PLEASE READ
Copy Fee for Patient Requests
Pages 1-10 FREE
Pages 11+ 0.25¢ per page

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Information (Please fill out form completely):

Last Name ______ First Name ______ M.I. ______

Address ______

City ______ State ______ Zip Code ______

Date of Birth ______ Social Security # ______

Telephone # (   ) - ______ Fax # (   ) - ______

Maiden or Other Names ______

I hereby authorize Providence Saint Joseph Medical Center to release protected health information to:

Person/Organization ______

Address ______

City ______ State ______ Zip Code ______

Telephone # (   ) - ______ Fax # (   ) - ______

The following information **Dates of Hospitalization:** ______

☐ Complete copy
☐ Lab/ X-ray report
☐ ER records
☐ Other/specify: ______
☐ Substance abuse treatment records
☐ HIV/Communicable Disease results
☐ Mental health/counseling records

For the purposes of (check one): ☐ Physician ☐ Insurance ☐ Legal ☐ Personal

Method of Delivery: ☐ Patient Pickup ☐ Mail

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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth, consistent with Federal and California state laws concerning the privacy of such information.

Failure to provide all information requested may invalidate this Authorization.

If my record contains any highly confidential information such as HIV tests or counseling records, and I want it released, I must check the proper box(es) above.

I understand I may inspect or copy the information used or disclosed.

I may refuse to sign this Authorization.

I may revoke this Authorization at any time. My revocation must be in writing.

My revocation will take effect upon receipt, except to the extent that the Requester or others have acted in reliance upon this Authorization.

This Authorization will expire in 90 days unless I specify an earlier date: ____________
Date Expires

Federal and state law prohibits the requestor from making further disclosure of the health information unless the requestor obtains another authorization from the patient or the disclosure is required or permitted by law.

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

____________	____________	____________
Signature of Patient	Print Name	Date
____________	____________	____________
Patient Representative Signature (attach appropriate documentation)	Print Name	Date