University of Southern California - Keck Medicine

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Information

Patient's Name: (last) ______________________________(first) ________________

Home Address:____

Email Address: ____

Home Phone: __________________________ Date of Birth _____________________

Information to be disclosed by Keck Hospital of USC and its Affiliates:

Dates of Service: from ___________________ to ___________________

☐ Pertinent Health Record (no fee, includes physician reports and test results)

☐ Specific Information:____

Locations/Providers of records you want released:

❏ Keck Hospital ❏ USC Norris Comprehensive Cancer Center

❏ Verdugo Hills Hospital ❏ USC CARE (Please specify Doctors):

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Sensitive Information

By applying a check next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the type of highly confidential information, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ Mental Illness
- ☐ Substance Abuse
- ☐ Communicable Disease
- ☐ Developmental Disability
- ☐ Genetic Testing
- ☐ HIV/AIDS Related
- ☐ Psychotherapy Notes
- ☐ Other:

____

Recipient (Select One)

☐ E-Mail Delivery (Address):____

☐ Mail

Name:____

Address: ____

☐ Pickup (I understand that if I do not pick up within 5 business days, the hospital will shred my records and I may have to start the process again)

Name:____

TERM: This Authorization shall remain in effect for a maximum of six (6) months from the date of signature, or until the __________ day of ___________________, 20____

PURPOSE: I authorize the use or disclosure of 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:

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I understand that once **Keck Hospital of USC and its affiliates** discloses my health information to the recipient, Keck Hospital of USC and its affiliates cannot guarantee that the recipient will not redisclose 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 Keck Hospital of USC and its affiliates may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may at any time make a written request to Keck Hospital of USC and its affiliates to inspect and/or obtain a copy of my health information, and that Keck Hospital of USC and its affiliates 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; except, however, if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Keck Hospital of USC and its affiliates may refuse to treat me if I do not sign this Authorization.

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 Keck Hospital of USC's Privacy Office 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 **Keck Hospital of USC**'s Privacy Office at the address listed below. The revocation will be effective immediately upon Keck Hospital of USC's receipt of my written notice, except that the revocation will not have any effect on any action taken by Keck Hospital of USC'in reliance on this Authorization before it received my written notice of revocation.

I may contact Keck Hospital of USC at (323) 442-8778.

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 Keck Hospital of USC to use or disclose my health information in the manner described above.

____________________	____________________	____________________
Name	**Signature**	**Date**

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

____________________	______________________________	____________
Name	**Signature of Personal Representative**	**Date**

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Description of Authority

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.

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Signature of employee validating identity