



12401 Washington Blvd.
Whittier, CA 90602
P: 562.698.0811
TDD: 562.696.9267

**AUTHORIZATION FOR USE
OR DISCLOSURE OF
HEALTH INFORMATION**



ACT: _____ MR: _____
DOB: _____
ADM: _____ RM: _____

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

PATIENT IDENTIFICATION (required)

Patient Name _____ DOB _____
Address _____
Home phone number _____ Cell phone number _____
Email address _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize:

- PIH Health Whittier Hospital 562.906.5695 PIH Health Downey Hospital 562.904.5166
- PIH Health Good Samaritan Hospital 213.977.2121 Ext. 8127
- PIH Health Physicians 562.698.0811 Ext. 13698 (or specific physician/clinic) _____
- _____

Other Healthcare Facility **to release** records

to release to myself or to _____
Healthcare Facility/Person/Organization **to receive** records

Address _____
Phone number _____ Fax number _____

the following information:

Only check one box in this section (A, B or C)

- A. Pertinent Information (Discharge Summary, History and Physical, Consultation, ER Reports, Labs, Radiology Reports, EKGs, Pathology Reports)
- B. All health information pertaining to my medical history, mental or physical condition and treatment received, including records received from other healthcare providers (reasonable clerical and reproduction processing fee is applicable)
- C. Only the following records or types of health information:

<input type="checkbox"/> Emergency/Urgent Care Physician Report	<input type="checkbox"/> Consultation Report	<input type="checkbox"/> History and Physical Report
<input type="checkbox"/> Discharge Summary Report	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Operative Report
<input type="checkbox"/> Anesthesia Records	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Pathology Slides	<input type="checkbox"/> Immunization Record	<input type="checkbox"/> Radiology Films/Images
<input type="checkbox"/> Newborn Record		<input type="checkbox"/> Therapy Records
<input type="checkbox"/> Other _____		

Specify **date** or **time period** for information selected above:

From (date) _____ To (date) _____

- D. I specifically authorize release of the following information:

<u>Check as appropriate</u>	<u>Initials</u>	<u>Initials</u>
<input type="checkbox"/> Mental health treatment information _____		<input type="checkbox"/> Alcohol/drug treatment information _____
<input type="checkbox"/> HIV test results _____		<input type="checkbox"/> Workers' Comp _____

Please provide my records by (if available) CD Portal



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PURPOSE

Purpose of requested use or disclosure

Patient request OR Other (state reason) _____

Limitations, if any _____

EXPIRATION

This authorization expires on (date) _____
(date cannot exceed one year from the date of this authorization)

MY RIGHTS

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time but I must do so in writing and submit it to the following address or fax:

PIH Health Whittier Hospital
HIM Department
12401 Washington Blvd
Whittier, CA 90602
Fax: 562.967.2908

PIH Health Downey Hospital
HIM Department
11500 Brookshire Ave
Downey, CA 90241
Fax: 562.967.2948

PIH Health Good Samaritan Hospital
HIM Department
1225 Wilshire Blvd
Los Angeles, CA 90017
Fax: 562.967.2358

PIH Health Physicians
HIM Department
12401 Washington Blvd
Whittier, CA 90602
Fax: 562.967.2938

My revocation will take effect upon receipt except to the extent that others have acted in reliance upon this authorization.

Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may 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.

A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization.

If signed by a person other than the patient, indicate relationship _____

Print name of legal representative _____

Signature _____ Date _____ Time _____ AM/PM

Patient/Legal Representative

Identification Verified by HIM Representative _____ (initials)