

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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

NOTE: If you are a patient/patient representative requesting medical records for personal use, there may be a fee for production of the medical records.

EXPLANATION

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003

Name of Patient:		
Date of Birth:	SSN:	
Address:		
Phone numbers:		
Home#:	Cell#	Work#

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby Authorize **St. Joseph Hospital** **St. Jude Medical Center**
 Mission Hospital **Mission Hospital Laguna Beach** **CHOC Children's at Mission Hospital**

to release my Medical Record to:

Name/Facility:	Attention:		
Address:	Phone:		
City:	State:	Zip:	FAX:

Mail a copy: address above Email a copy to: _____ @ _____
 Call when ready for pick-up: # _____ Fax to number above

INFORMATION TO BE RELEASED (Only check one box in this section)

Specify the Date or Time Period For the Information Above: _____
 Pertinent Information: **(This is what most patients and physicians need)** Discharge Summary, Emergency Department Report, History and Physical, Consultations, Operative Reports, Labs, Radiology Reports, EEG, EMG, EKG, Pathology Reports.

OR Entire Medical Record (a fee will be charged.)

OR Only the following records or types of health information:

AUTHORIZATION TO RELEASE STATUTORILY PROTECTED INFORMATION

I specifically authorize release of the following information (check and initial as appropriate):

Mental health treatment information	Initial and Date:
HIV test results	Initial and Date:
Alcohol/drug treatment information	Initial and Date:

A separate authorization is required to authorize the disclosure or use of psychotherapy notes



PURPOSE

Purpose of requested use or disclosure: Patient Request Continuing Care Legal Insurance
 Other: _____

EXPIRATION

This authorization expires (Date): _____

If no Date is given; this authorization will expire 6 months from the signature date.

MY RIGHTS

I may refuse to sign this authorization. If I refuse to sign this authorization, I should know that by law, my health information cannot be released. 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:

St. Joseph Hospital
Health Information Management-Correspondence
1100 West Stewart Drive
Orange, CA 92868

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

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE

Patient Signature: _____ Date: _____

Legal Representative Signature: _____ Date: _____
(Patient representative)

If signed by someone other than the patient, state your legal relationship to the patient and why you have the authority to act for the patient: _____

To release mental health records we must obtain authorization from the physician who attended the patient at St. Joseph Hospital and must be treated as confidential under State Regulation (Welfare & Institutions Code 5328).

HOSPITAL USE ONLY

PHYSICIAN RELEASE OF MEDICAL RECORD

APPROVED By Physician Name: _____ Date: _____ HIM Staff initials: _____

DENIED - REASON FOR DENIAL: _____

MD Signature: _____ Date: _____ Time: _____

Request completed by: _____ Date: _____