AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION

Patient Name: ______________________ Date of Birth: ______________

Address: ______________________ Telephone: ______________

City, State, Zip: ______________________

DISCLOSURE STATEMENT

I hereby authorize:

☐ Corona Regional Medical Center ☐ Other: ______________________

To release protected health information to the following person or entity:

Entity or Person: ______________________ Contact Name: ______________

Address: ______________________ Telephone: ______________

City, State, Zip: ______________________ Fax Number: ______________

HEALTH INFORMATION TO BE RELEASED

☐ Pertinent Information for Continuing Care ☐ Radiology Images (X-rays, MRI, CT…)
☐ History & Physical ☐ Radiology Reports ☐ Consultation Reports
☐ Laboratory Reports ☐ Discharge Instructions ☐ Discharge Summary
☐ Operative Reports ☐ Pathology Reports ☐ EKG/ECHO
☐ ER Report ☐ Entire Record (Fees will apply)
☐ Other: ______________________

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

☐ Alcohol or drug treatment ☐ HIV test results ☐Mental Health treatment records (other than psychotherapy notes
☐ Psychotherapy Notes Only[1]

REQUESTED SERVICE DATES

Please indicate the date(s) and/or time period for the information selected above:

☐ Most recent visit ☐ Date(s): ______________________

PURPOSE OF RELEASE:

Please indicate the purpose for this release:

☐ Continuing Care ☐ Patient Copy ☐ Other: ______________________

1 Psychotherapy Notes ONLY – IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES. IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

INFORMATION DELIVERY

How would you like to receive the requested health information?

☐ U.S. Mail ☐ Faxed to doctor's office/ health facility
☐ Pick up Corona Regional Medical Center, Health Information Management Department
☐ Other: ____

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 have a right to receive a copy of 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 unless or unless such disclosure is specifically required or permitted by law.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address 800 South Main Street, Corona, CA 92882. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

EXPIRATION

Unless otherwise revoked this Authorization expires ____________________ (insert date). If not date is indicated, it will expire upon its completion or 12 Months from date of signature, whichever comes first.

SIGNATURE

Signature: __________________________ Date: ___________ Time: ________ (AM/PM)

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

For office use only

Records released from

☐ Medical Records ☐ Laboratory ☐ Radiology ☐ Other: ___________________________

ID type: ___________________________ ID Number: ___________________________

Witness Signature: ___________________________ Date: ________________________

Witness Name: ______________________________