Little Company of Mary - San Pedro Hospital
1300 W. Seventh Street, San Pedro , CA 90732 (310) 514-5260

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Birthdate:_____ MR#: _____

Address: _____ Home Telephone: _____

Date(s) of Treatment: _____

Purpose of Release: ___ Physician ___ Attorney ___ Insurance ___ Other: _____

Information to be released from: *Little Company of Mary - San Pedro Hospital*

Information to be released to:

Name: _____

Address: _____

Information to be released (please check all that apply):

☐ Discharge Summary	☐ Operative Report(s)	☐ Lab/Cardiology report(s)
☐ History & Physical	☐ Pathology Report(s)	☐ X-ray and imaging report(s)
☐ Consultation report(s)	☐ Chemical Dependency	☐ Dates of Hospitalization
☐ Emergency Dept.Records	☐ Psychiatric Records	☐ Other_____

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

Failure to provide all information requested may invalidate this Authorization.

California law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to this facility. my revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this authorization. (Released information before revokation received).

This authorization expires on: _____ (or in six months if not specified).

Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Name of Requestor: _____ Date: _____

Patient Signature (or Responsible Party) X _____

Telephone Number of Requestor: _____

Relationship if other than patient: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling
☐ Guardian ☐ Other (specify) _____

Authorized Agent:
Knox Attorney Service, Inc./ Knox Services LLC.