Pomona Valley Hospital Medical Center

AUTHORIZATION TO USE/DISCLOSE (RELEASE) HEALTH INFORMATION

This authorization is for Use and Disclosure of Protected Health Information for reasons other than treatment, payment or healthcare operations.

PATIENT IDENTIFYING INFORMATION

Patient's Name _____

Date of Birth _____ Social Security Number _____

I authorize Pomona Valley Hospital Medical Center ("Hospital") to use or disclose (release) the above named patient's health information as described below.

The following individual or organization is authorized to receive/review the above named patient's health records. If records are being released for Personal Use, there will be a fee of $15.00 for the first 10 pages and $0.25 per page thereafter.

RELEASE RECORDS TO

Name /Organization _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

Purpose(s) of Disclosure _____

(Including any limitations on use or disclosure) _____

INFORMATION TO BE RELEASED

_____ Medical Records _____ Lab/Pathology Slides _____ Neuro/Sleep Studies

_____ X-ray Reports/Films _____ Emergency Records _____ Cardiology

_____ Physical Therapy _____ Other: Describe _____

Specify Dates of Treatment _____

I understand that the information in my health record may include information relating to sexually transmitted disease (STDs), AIDS or HIV. It also may include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Please Initial _____

YOUR RIGHTS

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to Pomona Valley Hospital Medical Center ATTN: Medical Records, Release of Information, 1798 N. Garey Avenue, Pomona, CA 91767

My revocation will be effective upon receipt, but will not be effective to the extent that the Hospital or others have acted in reliance upon this Authorization. For further information, please see Hospital's Notice of Privacy Practices.

It is possible that the information disclosed under this Authorization could be subject to redisclosure by the recipient and no longer protected by federal or state privacy laws.

I have a right to receive a copy of this Authorization. I acknowledge that this Authorization was filled out completely when I signed the Authorization.

I understand that there may be circumstances that would allow the Hospital to receive a fee in exchange for disclosing the information requested on this Authorization.

SIGNATURE

Signature of Patient/Legal Representative _____ Date _____

Relationship to Patient/Authority to Act for Patient _____

Witness _____ Identification Verified _____

Authorization Expires (Date or Event/Condition) _____

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