AUTHORIZATION FOR USE OF/OR DISCLOSURE OF MEDICAL INFORMATION

PRESBYTERIAN HOSPITAL

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

Failure to provide all information requested may invalidate this authorization.

Patient Name:	Phone Number:
Patient's Date of Birth:	I am the: ☐ Patient ☐ Guardian ☐ Conservator

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Presbyterian Intercommunitv Hospital to use or disclose medical information pertaining to my medical history, mental or physical condition, services rendered or treatment to:

Send to: *Name of the physician/person/agency that you want to receive the information, and the address.*

Name:		
Address:		
City:	State:	Zip Code:
Phone Number: ( )	Fax Number ( )	

The requester may use the *protected health information* and type of information authorized only for the following purposes:

Purpose of Your Request: ☐ Ongoing Medical Care ☐ Personal Use ☐ Other, Please specify:	
Time Period of Records You Want Released: From (date):	To (date):

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

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I authorize the following to be released:

☐ Emergency Department Visit	☐ Pathology Report	☐ PT/OT
☐ Discharge Summary	☐ Lab Report	☐ Spine Center
☐ History & Physical	☐ Blood Type	☐ Home Health
☐ Consultation	☐ X-Ray Report	☐ Hospice
☐ Progress Notes	☐ X-Ray Films	☐ A Day Away
☐ Operative Report	☐ EKG Report	☐ Clinic
☐ Anesthesia Record	☐ Newborn Record	

☐ Other, please specify:____

☐ **EXCEPTIONS, please specify.**________________________________

EXPIRATION

This authorization shall remain valid for one year from the date of signature unless specified by the following date, _____________

RESTRICTIONS

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.

YOUR RIGHTS

I may refuse to sign this authorization.

I may revoke this authorization at any time. If I choose to revoke my request, I understand that my request must be placed in writing, and must be signed by me, or my legal representative and delivered to the following address:

Presbyterian Intercommunity Hospital
Health Information Management Department
12401 Washington Boulevard
Whittier, CA 90602

My revocation will be effective upon receipt, but will not be effective to the extent that the organization has taken actions in reliance upon this authorization.

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

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ADDITIONAL COPIES
I further understand that I have the right to receive a copy of this authorization upon my request.
Copy requested and received:
☐ YES ☐ NO Initial:____________

IF REQUESTOR SEEKS THIS AUTHORIZATION
I may inspect or obtain a copy of the health information that I am authorizing for use or disclosure.

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

If this box ☐ is checked, the Requestor will receive compensation for the use or disclosure of my information. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might 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,
SIGNATURE

Date:________________________ **Time:**______________**AM/PM**

Signature:____
[patient/legal representative]

If signed by someone other than the patient state your legal relationship to the patient.

Relationship:____

Witness:____
(If you, have authorized the disclosure of your health information to someone, who is not legally required to keep it confidential, it may be redisclosed and *may no longer be protected. California law prohibits recipients of your health information from re-disclosing such information except with your written authorization or as specifically required or permitted by law.)*

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