St. John's Regional Medical Center
St. John's Pleasant Valley Hospital
CHW

St. John's Regional Medical Center
1600 North Rose Avenue
Oxnard, CA 93030
805 988 2500 Telephone

St. John's Pleasant Valley Hospital
2309 Antonio Avenue
Camarillo, CA 93010
805 389 5800 Telephone

AUTHORIZATION FOR USE AND / OR DISCLOSEURE OF PROTECTED HEALTH INFORMATION

(Note: Do Not Use This Form If Records To Be Released Relate to HIV Test Results)

EXPALNATION: This Authorization is necessary for us to comply with state and federal laws pertaining to the use or disclosure of protected heath information ("PHI") about the patient identification below. Please provide all requested information. Failure to provide all required information may prevent (Hospital or facility name) from acting on this Authorization.

Name Of Patient_____ **Date of Birth** _____
Other Name_____ **M.R. or Account #**_____

1. **PERSONS AUTHORIZATION TO DISCLOSE PHI. I authorize the following person(s) or class of persons to disclose the health information about as described in Section 2 below : (State name of physician or specific identification of the person or class of persons)**_____
_____

2. **DESCRIPTION OF INFORMATION. This Authorization permits the use and/or disclosure of the following information about the patient: (Check all applicable boxes and initial selection as required.)**
___ _____ **(Initial) All my health information pertaining to any medical history, physical condition and treatment Received Except (optional):**_____
Or, only the following records or types of health information and/or only on the specified date(s):
Date(s) of Treatment _____ **Type of Treatment:**_____

___ Billing Records	___ EKG Results	___ Medications	___ Operative Report	___ X- Ray Results
___ Consultation	___ History & Physical	___ Nurse's Notes	___ Pathology Report	___ Emergency
___ Discharge Summary	___ Lab Reports	___ Orders	___ Progress Notes	___ Room Records

___ **All health information relating to above dates(s) or type of treatment**
____ **(Initial) Others** _____
_____

3.___ **(Initial) Records of Diagnosis or treatment for HIV, HIV- related illness, AIDS, or AIDS- related and communicable disease-related Illness.(Note: DO NOT USE THIS FORM IF records to be released relate to HIV Test Results. Use instead the AUTHORIZATION FOR THE USE AND DISCLOSURE ON HIV TEST RESULTS FORM)**
___ **(Initial) Records of treatment for drug or alcohol abuse.**
___ **AUTHORIZATED USERS AND RECIPIENTS. I hereby authorize the following person or class of person to receive and or use health described in Section 2 above: (State name and title (if applicable)**

Name:_____**4.Adresss**_
_____**City/State/Zip**_____ **PURPOSE, I hereby authorize the information checked in Section 2 above to be used and/or disclosed for the following purpose: (Check all applicable boxes)**

_____

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

Others: _____

_____

5. **RIGHT OF REVOCATION:** I understand that I have the right to revoke this authorization at any time, provided that my revocation is in writing and conforms to requirements described in (hospital or facility name). Notice of Privacy Practices, which is available online at WWW.chw.eduprivacy, or in person at (hospital or facility name).

6. **LIMITS TO REVOCATION.** I understand that my revocation will be effective upon its receipt by the person(s) I authorized in Section 1, but would not be effective to the extent that such persons have acted in accordance with this Authorization and in reliance thereon. With respect to the Person(s) authorized to receive and use health information described in Section 3, If patient (or personal representative) requested this Authorization, any revocation will be effective only when I communicate my revocation directly to them.

7. **REDISCLOSURE.** I understand that if the recipient of my information in Section 3, above is not a healthcare provider, a health plan or health care clearing house or not an entity required to comply with federal or state health privacy regulations. My health information may be further disclosed, by such recipient, and my information may no longer be protected by state and federal laws. If this Authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the substance abuse information under federal substance abuse information under federal substance abuse confidentiality requirements.

8. **CALIFORNIA / ARIZONA RESTRICTION.** I understand that a recipient of medical information in California or Arizona my not further disclose medical information about my (patient) unless a new Authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.

9. **RIGHT TO REFUSE TO SIGN.** I understand that I do not have to sign this Authorization and that my failure to sign this authorization will not effect my ability to obtain treatment, payment or benefits.

10. **AUTOMATIC ONE-YEAR DURATION,** This Authorization will automatically expire after one (1) year from date of execution unless a different end date or event is specified below.

11. **COPY RECEIVED,** I acknowledge receipt of a signed copy of his authorization_____ (initial)

12. _____ _____

Signature of patient (or personal representative, If applicable) Date

_____ _____

Print name of personal representative (If applicable)
(Legal representative, parent, spouse, financialy responsible party)

Relationship to patient (if signatory is anyone other than patient described signatory's relationship to patient.)

_____ _____

Address Witness (optional)

_____ _____

Phone No. Type of ID Presented. Attach Copy (Optional)

Patient/ Representative Identification Verified : Yes___ No ____ Initials _____ Department_____

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