

# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information, about you. Failure to provide all information requested may invalidate this Authorization.

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

## USE AND DISCLOSURE OR HEALTH INFORMATION

I hereby authorize \_\_\_\_\_ to

release to: \_\_\_\_\_ **Covering the period** of healthcare from \_\_\_\_\_ to \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax: \_\_\_\_\_

(Persons/Organizations authorized to receive the information) (Address- street, city, state, zip code, fax number and/or Email:)

The following information:

a. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received. – **OR**

☐ Only the following records or types of health information (including any dates):

☐ Discharge Summary

☐ Consultation(s)

☐ All pertinent Lab/X-rays/EKG

☐ History and Physical

☐ Operative Report

☐ Other: \_\_\_\_\_

☐ Rehab

☐ ER

b. I specifically authorize release of the following information (initial as appropriate):

☐ Mental health treatment information

☐ STD

☐ HIV test results

☐ Sexual Assault

☐ Alcohol/drug treatment information

☐ Child Abuse/Neglect

☐ Outpatient psychotherapy notes

## PURPOSE

Purpose of requested use of disclosure: ☐ patient request; **OR** ☐ other



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PATIENT ID

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## EXPIRATION

This authorization expires on \_\_\_\_\_

## 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 may revoke this authorization at any time, but I must do so in writing and submit to:

Centinela Hospital Medical Center  
ATTN: Medical Records  
555 E. Hardy Street  
Inglewood, CA 90301

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization. I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected 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 or unless such disclosure is specifically required or permitted by law.

Options of Electronic Format: According to HITECH section 13405 (e) (1); 42 U.S.C. 17935 (e) (1), you may have your electronic medical records transmitted to you or another entity in electronic format. Please choose which type of format you would like the information to be delivered in and note the receiving entity may not accept records in electronic format:

☐ Burn to CD    ☐ Paper    ☐ Email

## SIGNATURE

Date: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

Signature: \_\_\_\_\_  
(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient. Licensed Psychotherapist's approval or geropsychiatric patient:

Witness: \_\_\_\_\_



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PATIENT ID