Parkview Community Hospital Medical Center
AHMC Healthcare

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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

Name of patient: _____ Date of Birth: _____
Phone Number: _____ **Please provide valid ID for authentication.**
E-mail Address: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: _____
to release to:

_____

(Persons/Organizations authorized to receive the information)(Address—street,

_____

city, state, zipcode)

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):

_____

_____

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

❑ HIV test results _____ (initial)

❑ Alcohol/drug treatment information _____ (initial)

A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.[1]

(over)

1 Health care providers that do not maintain psychotherapy notes as defined in HIPAA may wish to delete this sentence.

PURPOSE

Purpose of requested use or disclosure: ❑ Patient request; OR ❑ Other:

_____

_____

_____

Limitations, if any: _____

_____

_____

EXPIRATION

This authorization expires on *(date)*: _____

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.[2]
- 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 anytime, but I must do so in writing[3] and submit it to the following address: _____.

  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.[4]

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2 If any of the HIPAArecognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual ofa refusalto sign theauthorization when thatcovered entitycan condition treatment,health plan enrollment,or benefiteligibility on thefailure to obtain suchauthorization.Acovered entity ispermitted tocondition treatment,health plan enrollmentor benefiteligibility onthe provisionof an authorization asfollows:(i)toconductresearch-relatedtreatment,(ii)toobtaininformationinconnectionwithahealthplan'seligibilityorenrollmentdeterminationsrelating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure ofthehealthinformationtosuchthirdparty.Undernocircumstances,however,mayanindividualberequiredtoauthorizethedisclosureofpsychotherapynotes.

3 Patients of federally-assisted substance abuse programs and patients whose records are covered by LPS may revoke an authorization verbally.

4 Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses anddisclosures*(see45 C.F.R.Section164.508(c)(4))*.

- In formation disclosed pursuant to this authorization could be redisclosed by the recipient. Such re-disclosure is in some cases not prohibited 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.

SIGNATURE

Date:_____ Time:_____ AM / PM

Signature:_____
(patient/legal representative)

If signed by a person other than the patient, indicate relationship:

_____

Print name:
(legal representative)

NOTES FOR PROVIDERS THAT USE THIS FORM:

- If the purpose of the authorization is to use the information for marketing by a third party that remunerates the provider, a statement to this effect must be included in this authorization form.
- If the purpose of the authorization is for the sale of protected health information (PHI), this form must state whether the PHI can be further exchanged for remuneration by the initial recipient.
- A provider that discloses healthin formation pursuant to an authorization must communicate any limitation contained in the authorization to the recipient [Civil Code Section 56.14]. The required notification may be accomplished by giving the recipient a copy of the authorization form.