Henry Mayo
Newhall Hospital

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED 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: ________________________________ DOB: ______________

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: ____
to release to:

____
(Persons/Organizations authorized to receive the information)

____
(Address – street, city, state, zip code)

____
(Email Address)

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):

❑ Mental health treatment information _____ (initial)
❑ 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.

PURPOSE

Purpose of request use or disclosure: ❑ Patient request; **or** ❑ Other:

____

____

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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.
- 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 it to the following address: **23845 McBean Parkway, Valencia, CA 91355 Att: Health Information Management Department.** 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 redisclosed by the recipient. Such redisclosure 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.
- I have a right to request that health information be sent to me using unsecured email even though there is some risk that the information may be read by a third party.

  ______ (Initials) I am requesting unsecure email transmission of requested health information to me related to this request. *(Applies only if you are recipient)*

SIGNATURE

Date: _______________________ Time: _______________________ A.M./P. M.

Signature: ____
(patient/legal representative)

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

Print name: ____
(legal representative)

For Internal Use Only
Date Request Received: __________________
Date Request Completed: _________________
Order Number: _________________________
MRN/Account Number: ___________________
Identity of Requestor Verified via: ❑ Photo ID
❑ Matching Signature ❑ Other (specify) ________________
Verified by: _____________________________