150000AUTH

PROVIDENCE
Health & Services
California

501 S. Bucna Vista St
Burbank, CA 91505
Office: (818) 847-3801
Fax: (818) 847-3913

IMPORTANT-PLEASE READ
Copy Fee for Patient Requests
Pages 1-10 FREE
Pages 11+ 0.25¢ per page

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Information:

_____ _____ _____
Last Name First Name M.I.

_____
Address

_____ _____ _____
City State Zip code

_____ XXX-XX-_____
Date of Birth (Last 4 digits) of SSN#

(_____)_____-_____ (_____)_____-_____
Telephone # Fax #

_____
Maiden or Other names

I hereby authorize Providence Saint Joseph Medical Center to release protected health information to:

_____
Person/Organization

_____
Address

_____ _____ _____
City State Zip code

(_____)_____-_____ (_____)_____-_____
Telephone # Fax #

☐ **Providence Saint Joseph Medical Center** ☐ **Valley Radiation Oncology Center**
☐ **Disney Family Cancer Center** ☐ **PT/OT/Home Health** ☐ **Occupational Health Center**

Dates of Service(s): from _____ **to** _____

The following information
☐ All health information
☐ All pertinent records, **OR** check all that apply below:

☐ Labs ☐ Operative report ☐ ER Reports
☐ X-ray/Radiology ☐ Cardiology/ EKG/ECHO ☐ Labor & Delivery
☐ H&P/DC Summary/Consults ☐ Pathology Report ☐ Other/Specify:_____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I specifically authorize the release of the following specialized information (check as appropriate): ☐ Substance abuse treatment records _____(Initial)
☐ Mental health/counseling records_____(Initial)
☐ HIV/Communicable Disease Results_____(Initial)

For the purposes of: ☐ Physician ☐ Insurance ☐ Legal ☐ Personal Use
☐ Other /Specify:_____

Method of Delivery: ☐ Patient Pickup (only available for patient access) ☐ Mail

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 it to the following address: Providence Saint Joseph Medical Center, Health Information Management, 501 S. Buena Vista Burbank, CA 91505.

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 the authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such redisclosure 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.

Signature of Patient	Print Name	Date

If signed by someone other than the patient, state your legal relationship to the patient and provide appropriate documentation that verifies this relationship. If patient is deceased, please provide a copy of death certificate.

Representative Signature	Print Name	Relationship to Patient	Date

Witness: _____