

Patient Name \_\_\_\_\_

MR# \_\_\_\_\_



# Desert Regional

## Medical Center

Tenet California

### AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

<b>Patient Name:</b>	_____		
	Last	First	Middle
<b>Home Address:</b>	_____		
	_____		
<b>Home Telephone:</b>	_____		
<b>Date of Birth:</b>	_____		
<b>Specify Information to be Disclosed:</b>			
_____			
_____			
_____			
By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:			
<input type="checkbox"/>	Mental Illness	_____	
<input type="checkbox"/>	Developmental Disability	_____	
<input type="checkbox"/>	Psychotherapy Notes	_____	
<input type="checkbox"/>	HIV/AIDS Testing, Diagnosis, or Treatment (regardless of result)	_____	
<input type="checkbox"/>	Communicable Disease	_____	
<input type="checkbox"/>	Substance Abuse, Prevention or Treatment	_____	
<input type="checkbox"/>	Sexual Assault	_____	
<input type="checkbox"/>	Child Abuse or Neglect	_____	
<input type="checkbox"/>	Genetic Testing	_____	
<input type="checkbox"/>	Domestic Abuse	_____	
<input type="checkbox"/>	Elder Abuse	_____	
<input type="checkbox"/>	Other	_____	

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Description: *	Date(s)*	Description:	Date(s)*
<input type="checkbox"/> History and Physical <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Laboratory Tests <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Progress Notes <input type="checkbox"/> Consultation Reports <input type="checkbox"/> Transfer Notes <input type="checkbox"/> ER Information <input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy		<input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Psychiatric Assessments <input type="checkbox"/> Psychosocial History <input type="checkbox"/> Psychosocial Notes <input type="checkbox"/> Labor/delivery summary <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> Other: <input type="checkbox"/> Other	

**RECIPIENT: Name of person or class of persons to whom Desert Regional Medical Center may disclose my health information:**

**ADDRESS: Address of the recipient or where my health information should be delivered:**

**TERM: This Authorization will expire on:**

The \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_\_.

**PURPOSE: I authorize Desert Regional Medical Center to use or disclose my health information (including the highly confidential I selected above, if any) during the term of this Authorization for the following specific purpose(s): Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization:**

Patient Name \_\_\_\_\_

MR# \_\_\_\_\_

I understand that once Desert Regional Medical Center discloses my health information to the recipient, Desert Regional Medical Center cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable law governing the use and disclosure of my health information.

I understand that I may at any time make a written request to Desert Regional Medical Center to inspect and/or obtain a copy of my health information, and that Desert Regional Medical Center will either, within five days for a request to inspect and fifteen days for a request to copy, grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Desert Regional Medical Center; except, however, if my treatment at Desert Regional Medical Center is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Desert Regional Medical Center may refuse to treat me if I do

I understand that, at any time during which this Authorization is in effect, I may make a written request to receive a copy of this Authorization. Such written request shall be made to Desert Regional Medical Center Privacy Office at the address listed below.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Desert Regional Medical Center's Privacy Office at the address listed below. The revocation will be effective immediately upon Desert Regional Medical Center's receipt of my written notice, except that the revocation will not have any effect on any action taken by Desert Regional Medical Center in reliance on this Authorization before it received my written notice of revocation.

**I may contact Desert Regional Medical Center's Privacy Office by mail at 1150 N. Indian Canyon, Palm Springs, CA 92262, by telephone at (760) 323-6289 or fax at (760) 323-6383.**

Patient Name

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I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Desert Regional Medical Center to use or disclose my health information in the manner described above.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

**If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:**

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Description of Authority

\_\_\_\_\_  
Date

**For Internal Use Only:** The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records.

\_\_\_\_\_  
Signature of employee validating identity