

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

MEDICAL RECORD NUMBER: \_\_\_\_\_ DATE: \_\_\_\_\_

RELATIONSHIP TO PATIENT:  SELF  PARENT  LEGAL GUARDIAN  OTHER: \_\_\_\_\_

**Patient Information**

Last Name	First	MI	Date of Birth	
Address		City	State	Zip
			(____) _____	Phone

**HEREBY AUTHORIZES**

<input type="checkbox"/> LAC+USC Medical Center	<input type="checkbox"/> Rancho Los Amigos National Rehabilitation Center			
<input type="checkbox"/> Olive View Medical Center	<input type="checkbox"/> High Desert Regional Health Center			
<input type="checkbox"/> Harbor-UCLA Medical Center	<input type="checkbox"/> Martin Luther King, Jr. Outpatient Center			
<input type="checkbox"/> CHC/Health Center: _____				
<input type="checkbox"/> Other: _____				
Facility Name	Street Address	City	State	Zip Code

**To Release Protected Health Information To:**

Name of Facility/Health Care Provider/Plan/Other	Street Address
City	State
	Zip Code

for the time period beginning, \_\_\_\_\_ Date \_\_\_\_\_, and ending \_\_\_\_\_ Date \_\_\_\_\_.

**EXPIRATION DATE:** This authorization is valid until the following date: \_\_\_\_\_ / \_\_\_\_\_ / 20 \_\_\_\_\_

**INFORMATION TO BE DISCLOSED**

**PLEASE CHECK ALL APPROPRIATE BOXES:**

- |  |   |
|--|---|
| <input type="checkbox"/> Discharge Summary             | <input type="checkbox"/> Mental Illness or Mental Health Assessment |
| <input type="checkbox"/> History and Physical          | <input type="checkbox"/> Drug and/or Alcohol Abuse Treatment        |
| <input type="checkbox"/> Consultation                  | <input type="checkbox"/> HIV/AIDS                                   |
| <input type="checkbox"/> Operative Report              | <input type="checkbox"/> Sexually Transmitted Disease(s)            |
| <input type="checkbox"/> Radiology Report              | <input type="checkbox"/> EKG Report                                 |
| <input type="checkbox"/> Radiology Films               | <input type="checkbox"/> EEG Report                                 |
| <input type="checkbox"/> Laboratory / Diagnostic Tests | <input type="checkbox"/> Summary of Medical History / Treatment     |
| <input type="checkbox"/> Medical Progress Notes        |   |
| <input type="checkbox"/> Other (Please Specify): _____ |   |

MRUN
NAME
DOB/GENDER



**THE PURPOSE OF THE DISCLOSURE - PROVIDE A DESCRIPTION OF THE PURPOSE OF INTENDED USE AND DISCLOSURE**

I understand that health information used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

**Right to Receive a Copy of This Authorization** –I understand that if I sign this authorization, I will be provided with a signed copy of the form.

**CONDITIONS:** I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, DHS may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient/Legal Representative \_\_\_\_\_ Print Name \_\_\_\_\_

If signed by other than the patient, state relationship and authority to do so: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Witness: \_\_\_\_\_ Print Name: \_\_\_\_\_

**Right to Revoke This Authorization** – I understand that I have the right to revoke this Authorization at any time by telling DHS in writing. I may use the Revocation of Authorization at the bottom of this form. Mail of deliver the revocation to the following facility address:

I also understand that a revocation will not affect the ability of DHS or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization.

**REVOCAION OF AUTHORIZATION**

**Signature of Patient/Legal Representative:**

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If signed by other than patient, state relationship and authority to do so:

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MRUN

NAME

DOB/GENDER

