

## AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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

**NOTE: If you are a patient/patient representative requesting medical records for personal use, there may be a fee for production of the medical records.**

### EXPLANATION

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003

Name of Patient:		
Date of Birth:	SSN:	
Address:		
Phone numbers:		
Home#:	Cell#	Work#

### USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby Authorize  **St. Joseph Hospital**    **St. Jude Medical Center**  
 **Mission Hospital**    **Mission Hospital Laguna Beach**    **CHOC Children's at Mission Hospital**

to release my Medical Record to:

Name/Facility:	Attention:		
Address:	Phone:		
City:	State:	Zip:	FAX:

Mail a copy: address above    Email a copy to: \_\_\_\_\_ @ \_\_\_\_\_  
 Call when ready for pick-up: # \_\_\_\_\_    Fax to number above

### INFORMATION TO BE RELEASED (Only check one box in this section)

Specify the Date or Time Period For the Information Above: \_\_\_\_\_  
 Pertinent Information: **(This is what most patients and physicians need)** Discharge Summary, Emergency Department Report, History and Physical, Consultations, Operative Reports, Labs, Radiology Reports, EEG, EMG, EKG, Pathology Reports.  
**OR**  Entire Medical Record (a fee will be charged.)  
**OR**  Only the following records or types of health information:

### AUTHORIZATION TO RELEASE STATUTORILY PROTECTED INFORMATION

I specifically authorize release of the following information (check and initial as appropriate):

Mental health treatment information	Initial and Date:
HIV test results	Initial and Date:
Alcohol/drug treatment information	Initial and Date:

A separate authorization is required to authorize the disclosure or use of psychotherapy notes



**PURPOSE**

Purpose of requested use or disclosure:  Patient Request  Continuing Care  Legal  Insurance  
 Other: \_\_\_\_\_

**EXPIRATION**

This authorization expires (Date): \_\_\_\_\_

If no Date is given; this authorization will expire 6 months from the signature date.

**MY RIGHTS**

I may refuse to sign this authorization. If I refuse to sign this authorization, I should know that by law, my health information cannot be released. 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:

**St. Joseph Hospital**  
**Health Information Management-Correspondence**  
**1100 West Stewart Drive**  
**Orange, CA 92868**

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 re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

**SIGNATURE**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient representative)

If signed by someone other than the patient, state your legal relationship to the patient and why you have the authority to act for the patient: \_\_\_\_\_

To release mental health records we must obtain authorization from the physician who attended the patient at St. Joseph Hospital and must be treated as confidential under State Regulation (Welfare & Institutions Code 5328).

**THE FOLLOWING IS FOR HOSPITAL USE ONLY**  
**PHYSICIAN RELEASE OF MEDICAL RECORD**

APPROVED By Physician Name: \_\_\_\_\_ Date: \_\_\_\_\_ HIM Staff initials: \_\_\_\_\_

DENIED - REASON FOR DENIAL: \_\_\_\_\_

MD Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_