PALMDALE REGIONAL MEDICAL CENTER

AUTHORIZATION TO RELEASE HEALTH INFORMATION

38600 Medical Center Drive
Palmdale, California 93551
Unit – Medical Records
Phone – 661 382 5048
Fax – 661 382 5499

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.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Palmdale Regional Medical Center

to release to:

_____

(Persons/Organizations authorized to *receive* the information) (Address—street, city, state, zip code)

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 include any dates:

_____

b. I specifically authorize release of the following information (check as appropriate):

❑ Mental health treatment information[1]

❑ HIV test results

❑ Alcohol/drug treatment information

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

_____ _____ _____

Patient Name (Print) Date of Birth Social Security Number

_____

Signature

_____ _____

Street Address Phone #

_____

City, State, Zip Code

PURPOSE

[1] If mental health information covered by the Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.

Purpose of requested use or disclosure: ❑ patient request; ***OR*** ❑ other: _____

_____

EXPIRATION

This Authorization expires [insert date or event]:[2]_____

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.[3]

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: **38600 Medical Center Drive, Palmdale, California 93551.**

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.[4]

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).

If this box ❑ is checked, the Requestor will receive compensation for the use or disclosure of my information.[5]

SIGNATURE

Date: _____ Time: _____ am/pm

Signature: _____
(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:

_____

Witness:_____

[2] If authorization is for use or disclosure of protected health information for research, including the creation and maintenance of a research database or repository, the statement "end of research study," "none" or similar language is sufficient.

[3] If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

[4] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures *(see 45 C.F.R. Section 164.508(d)(1), (e)(2)).*

[5] The requestor is to complete this section of the form.