Authorization for Use or Disclosure of Health Information

Community Memorial HEALTHCARE

Patient's Name _____ Birth Date _____ MR# _____ Bill # _____

Address _____ City _____ State _____ Zip Code _____

Phone(s) _____ E-Mail _____

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.

Failure to provide all information requested may invalidate this authorization.

NOTICE OF RIGHTS AND OTHER INFORMATION

1. I understand that this authorization is voluntary.
2. I may refuse to sign this authorization.
3. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization. I understand the Notice of Privacy Practices provides instruction should I choose to revoke my authorization.
4. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
5. Information disclosed pursuant to this authorization could be re-disclosed by the recipient 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.
6. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
7. If this box ☐ is checked, the requestor will receive compensation for the use or disclosure of my information.
8. I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to: Community Memorial Healthcare, Health Information Department, 147 North Brent Street, Ventura, CA 93003.
9. I understand that I have the right to choose how I am to receive my health information.
   a. Please choose a mode of delivery (choose one option)
      - ☐ 1. Mail (address listed below)
      - ☐ 2. Secure email to email of recipient below _____
      - ☐ 3. Fax records to Fax # (patient or outside entity) _____
      - ☐ 4. In-person

   b. Please choose a format (choose one option)
      - ☐ 1. Paper
      - ☐ 2. CD ☐ Flash Drive
      - ☐ 3. Electronic file in "pdf" format

   · Please be advised that with utilizing fax or secure e-mail, there is some level of risk that your requested health information could be read or otherwise accessed by a third party while in transit.

I understand I have the right to receive a copy of this authorization. (Civ. Code § 56.12)

I hereby authorize: ☐ Community Memorial Hospital - Ventura ☐ Community Memorial Hospital - Ojai
☐ Community Memorial Health Centers (specify location) _____
☐ Other entity _____

_____

Release to _____
(PERSONS / ORGANIZATIONS AUTHORIZED TO RECEIVE THE INFORMATION)

Address _____ City _____ State _____ Zip Code _____

LGL801

PLEASE SEE BACK FOR MORE INFORMATION

This authorization applies to the following information (select from the following)

☐ Entire medical record	☐ H&P/consult	☐ HIV test results
☐ Lab	☐ Operative report	☐ Alcohol/drug treatment
☐ Itemized billing statement	☐ Discharge summary	☐ ER record
☐ X-ray report	☐ Mental health notes (must use psychotherapy release form)	
☐ Progress notes	☐ Pathology report	☐ X-ray images on CD (images obtained in radiology)
☐ Doctors orders	☐ Chart Notation:	☐ Other _____

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

Date(s) of service requested _____

PURPOSE

Description of each purpose of request use or disclosure _____

EXPIRATION

This authorization expires (insert date) _____

· This authorization expires one (1) year from date signed below if no expiration date inserted above.

SIGNATURE

Patient/Representative/Spouse/Financially Responsible Party signature _____

Date _____ Time _____ AM/PM

If signed by someone other than the patient, state your legal relationship _____
If patient's legal representative, please provide supporting documentaion such as power of Attorney, Death Certificate if patient is expired, Conservatorship or Proof of Custody.

☐ ID checked

I hereby authorize _____ to pick up my records.

☐ ID checked (during normal department operations)

Hospital representative processing request _____

Date _____

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Community Memorial Healthcare ~ Medical Records/Health Information Department 147 North Brent Street, Ventura, CA 93003
Phone 805-948-5047 ROIrequests@cmhshealth.org Fax 805-652-5649
Community Memorial Hospital-Ojai ~ Medical Records/Health Information Department ~ 1306 Maricopa Hwy., Ojai, CA 93023
Phone 805-640-2215 Fax 805-640-1649
Community Memorial Health Centers ~ Medical Records/Health Information Department
Please use Community Memorial Healthcare contact information above
Phone 805-948-5047 Fax 805-652-5649