AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

12401 Washington Blvd.
Whittier, CA 90602

P: 562.698.0811
TDD: 562.696.9267

www.pihhealth.org/patients-visitors/medical-records/

ACT: MR:

DOB:
ADM: RM:

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

PATIENT IDENTIFICATION (required)

Patient Name ____ DOB _____________
Address ____
Home phone number _____________________ Cell phone number _____________________
Email address ____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize:

☐ PIH Health Hospital - Whittier 562.906.5695 ☐ PIH Health Hospital - Downey 562.904.5166
☐ PIH Health Physicians 562.698.0811 Ext. 13698 (or specific physician/clinic) __________________
☐ ____
Other Healthcare Facility ***to release*** records

to release to myself or to ____
Healthcare Facility/Person/Organization ***to receive*** records
Address ____
Phone number ___________________________ Fax number ___________________________

the following information:

Only check one box in this section (A, B or C)

A. ☐ Pertinent Information (Discharge Summary, History and Physical, Consultation, ER Reports, Labs, Radiology Reports, EKGs, Pathology Reports)

B. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received, including records received from other healthcare providers (reasonable clerical and reproduction processing fee is applicable)

C. ☐ Only the following records or types of health information included in the following dates of service:

☐ Emergency/Urgent Care Physician Report ☐ History and Physical Report
☐ Discharge Summary Report ☐ Consultation Report ☐ Operative Report
☐ Anesthesia Records ☐ Laboratory Reports ☐ Pathology Report
☐ Pathology Slides ☐ Radiology Reports ☐ Radiology Films/Images
☐ Newborn Record ☐ Immunization Record ☐ Therapy Records
☐ Other ____

Specify **date** or **time period** for information selected above:

From (date) _________________ To (date) _________________

D. ☐ I specifically authorize release of the following information:

Check as appropriate	Initials		Initials
☐ Mental health treatment information	_____	☐ Alcohol/drug treatment information	_____
☐ HIV test results	_____	☐ Workers' Comp	_____

Please provide my records by *(if available)* ☐ CD ☐ Portal

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PURPOSE

Purpose of requested use or disclosure

☐ Patient request OR ☐ Other (state reason) ______________________________________

Limitations, if any ____

____

EXPIRATION

This authorization expires on (date) _______________________
(date cannot exceed one year from the date of this authorization)

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.
- 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 or fax:

PIH Health Hospital - Whittier
HIM Department
12401 Washington Blvd
Whittier, CA 90602
Fax: 562.967.2908

PIH Health Hospital - Downey
HIM Department
11500 Brookshire Ave
Downey, CA 90241
Fax: 562.967.2948

PIH Health Physicians
HIM Department
12401 Washington Blvd
Whittier, CA 90602
Fax: 562.967.2938

My revocation will take effect upon receipt except to the extent that others have acted in reliance upon this authorization.

Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law 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.

A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization.

If signed by a person other than the patient, indicate relationship ________________________________

Print name of legal representative ____

Signature ___________________________________ Date ____________ Time ______ AM/PM
Patient/Legal Representative

Identification Verified by HIM Representative _______ (initials)