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

☐ Los Angeles General Medical Center	☐ Rancho Los Amigos National Rehabilitation Center
☐ Olive View Medical Center	☐ High Desert Regional Health Center
☐ Harbor-UCLA Medical Center	☐ Martin Luther King, Jr. Outpatient Center
☐ CHC/Health Center: _____	
☐ 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, _____ , and ending _____.
Date Date

EXPIRATION DATE: This authorization is valid until the following date: _____ / _____ / 20 _____

INFORMATION TO BE DISCLOSED

PLEASE CHECK ALL APPROPRIATE BOXES:

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultation
- ☐ Operative Report
- ☐ Radiology Report
- ☐ Radiology Films
- ☐ Laboratory / Diagnostic Tests
- ☐ Medical Progress Notes
- ☐ Other (Please Specify): _____

- ☐ Mental Illness or Mental Health Assessment
- ☐ Drug and/or Alcohol Abuse Treatment
- ☐ HIV/AIDS
- ☐ Sexually Transmitted Disease(s)
- ☐ EKG Report
- ☐ EEG Report
- ☐ Summary of Medical History / Treatment

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.

REVOCATION OF AUTHORIZATION

Signature of Patient/Legal Representative:

_____

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

_____

MRUN

NAME

DOB/GENDER

T-HS1015

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