AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

County of Los Angeles Public Health | Health Services Los Angeles County

PATIENT INFORMATION (Type or print)			
Last Name:	**First Name:**		
Date of Birth:	**Last 4 digits of SSN:**		
Phone Number & Alternate Phone Number:	**Medical Record Number:**		
Street Address:	**City:**	**State:**	**Zip Code:**

RELEASE INFORMATION FROM:

☐ All Department of Health Services (DHS) facilities

- ☐ Harbor-UCLA Medical Center
- ☐ Los Angeles General Medical Center
- ☐ Olive View Medical Center
- ☐ Health Center: _____
- ☐ High Desert Regional Health Center
- ☐ Martin Luther King Jr. Outpatient Center
- ☐ Rancho Los Amigos National Rehabilitation Center
- ☐ Office of Diversion and Reentry

☐ Department of Public Heath (DPH)

☐ Correctional Health Services (CHS)

☐ **Organization/Department/Individual below:**

Name _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

Email Address: _____ Attention to: _____

SEND INFORMATION TO:

☐ **Organization/Department/Individual below:**

Name _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

Email Address: _____ Attention to: _____

REQUESTED FORMAT TO RECEIVE / SEND PROTECTED HEALTH INFORMATION

☐ Paper Copies ☐ Electronic Format ☐ Fax ☐ Email*

**The HIM department will send communications through encrypted email*

PATIENT LABEL
NAME
DOB
FIN#
MR#
SEX on ID

APPROVED FOR USE AT ALL DHS FACILITIES

SCAN INTO ELECTRONIC HEALTH RECORD

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I AUTHORIZE THE FOLLOWING MEDICAL RECORD INFORMATION TO BE RELEASED:

☐ History & Physical Exam
☐ Consultation Note
☐ Radiology / Diagnostic Report
☐ Discharge Summary
☐ Surgery / Operative Report
☐ Laboratory Result
☐ Inpatient Progress Note
☐ Pediatric Clinic Note
☐ Pathology Report
☐ Outpatient Progress Note
☐ Immunization Record
☐ EKG Report
☐ ED / UCC Notes
☐ Physical / Occupational / Speech Therapy Note
☐ All records (not including records requiring additional authorization)
☐ Case Management Notes

ADDITIONAL AUTHORIZATIONS:

If you wish to request this information**, please initial next to the record you authorize to release**.

State and Federal laws provide additional protection for the following health information.

_____ HIV Testing and Results

The following requires review and approval from treating Provider

_____ Behavioral Health / Psychiatric Evaluation
_____ Behavioral Health / Psychiatric Treatment Records
_____ Psychological Test / Assessment Report
_____ Behavioral Health / Psychiatric Progress Notes
_____ Psychiatric Admission Records
_____ Psychology/Social Worker Note
_____ Gender Affirming Care
_____ Contraception or Abortive Services
_____ Pediatric HUB Clinic (excludes forensic recordings)

SPECIFIED DATES OF SERVICE

FROM: _____/_____/_____ TO: _____/_____/_____ ☐ ALL DATES

DESCRIPTION OF THE PURPOSE OF THIS DISCLOSURE

☐ At the request of the individual ☐ Continuity of Care ☐ Other: _____

EXPIRATION DATE

This Authorization is valid for one year from date of signature unless otherwise specified below:
_____/_____/_____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to receive a copy of this authorization: I understand that if I sign this authorization, I must be provided 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

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authorization to use or disclose protected health information created for that research-related treatment. (In plain terms, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

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 HIPAA. However, California law prohibits the person receiving my health information form making further disclosure unless another authorization for such disclosure is obtained from me or such disclosure is specifically required or permitted by law.

Right to revoke this authorization: I understand that I have the right to revoke this authorization at any time by informing DHS in writing. I may use the Revocation of Authorization included with this form (see below). 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 previously shared based on my authorization.

If you choose to revoke this Authorization, please mail, or deliver the revocation to the location where you requested your medical records.

AUTHORIZATION SIGNATURE: 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.

_____ _____ _____

Patient Name or Authorized Representative (PRINT) | *Patient or Authorized Representative Signature* | *Date*

Relationship to Patient: ☐ *Self* ☐ *Parent* ☐ *Legal Guardian* ☐ *Power of Attorney* ☐ *Conservator*
☐ *Other:* _____

REQUEST TO REVOKE THIS AUTHORIZATION

_____ _____ _____

Patient Name or Authorized Representative (PRINT) | *Patient or Authorized Representative Signature* | *Date*

Relationship to Patient: ☐ *Self* ☐ *Parent* ☐ *Legal Guardian* ☐ *Power of Attorney* ☐ *Conservator*
☐ *Other:* _____

FOR OFFICE USE ONLY

Type of Identification Provided: ☐ *State Driver's License* ☐ *State Identification Card*
☐ *Other:* _____

Facility: _____

Request processed by: _____ _____

(PRINT NAME) *Date:*

PATIENT LABEL
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