AUTHORIZATION TO USE and DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:	_____ Last First Middle	
List any other names you may have used when being cared for at LRMC	_____ Last Name (i.e. maiden name or previous married name) _____ First Name (nickname)	
Home Address:		
Telephone:	Home ( )	Cel ( )
Date of Birth:		

Specify Information to be Disclosed:

❒ Discharge Summ ❒ H&P ❒ Operative Report ❒ Pathology Report
❒ Consultations ❒ Progress Notes ❒ Laboratory Results ❒ Radiology Results
❒ Cardiology Results ❒ Neurology Results ❒ Physician Orders ❒ Emergency Dept
❒ Entire Medical Record ❒ Radiology Imaging on CD ❒ Other (specify below):

_____

By applying a check next to a category of **highly confidential information listed below** and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:

☐ Mental Illness _____
☐ Developmental Disability_____
☐ Psychotherapy Notes _____
☐ HIV/AIDS Testing, Diagnosis, or Treatment (regardless of result) _____
☐ HIV Test Result _____
☐ Communicable Disease _____
☐ Substance Abuse, Prevention or Treatment _____
☐ Sexual Assault _____
☐ Child Abuse or Neglect _____
☐ Genetic Testing _____
☐ Domestic Abuse _____
☐ Elder Abuse _____
☐ Other _____

MRN:

ACCT#:

Lakewood Regional Medical Center

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RECIPIENT: Name of person / group to whom LRMC may disclose my health information:
ADDRESS: Address of Recipient or where my health information should be delivered:
TERM: This Authorization will remain in effect from the date of this Authorization until 1. ☐ the _____ day of _____, 201_____. 2. ☐ This request has been fulfilled.
PICKUP: If applicable, specify date of pickup and name of person to pick up:
PURPOSE: I authorize Lakewood Regional Medical Center to use or disclose my health information (including the highly confidential I selected above, if any) during the term of this Authorization for the following specific purpose(s): Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization: _____ _____

I understand that once Lakewood Regional Medical Center (LRMC) discloses my health information to the recipient, LRMC cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable law governing the use and disclosure of my health information.

I understand that LRMC may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may at any time make a written request to LRMC to inspect and/or obtain a copy of my health information, and that Lakewood Regional Medical Center will either, within five days for a request to inspect and fifteen days for a request to copy, grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at LRMC; except, however, if my treatment at LRMC is for the

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ACCT#:

sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case LRMC may refuse to treat me if I do not sign this Authorization.

I understand that, at any time during which this Authorization is in effect, I may make a written request to receive a copy of this Authorization. Such written request shall be made to LRMC Privacy Office at the address listed below.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to LRMC Privacy Office at the address listed below. The revocation will be effective immediately upon LRMC's receipt of my written notice, except that the revocation will not have any effect on any action taken by Lakewood Regional Medical Center in reliance on this Authorization before it received my written notice of revocation.

I understand I may contact Lakewood Regional Medical Center's Privacy Office by mail at 3700 East South Street, Lakewood, CA 90712, or by telephone at 562.602.6416.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my protected health information.

By my signature below, I hereby, knowingly and voluntarily, authorize Lakewood Regional Medical Center to use or disclose my protected health information in the manner described above.

_____ _____

Signature of Patient **Date**

If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____

Signature of Personal Representative **Date**

_____

Description of Authority/Relationship to Minor

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For Internal Use Only: The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records.

_____	_____
Signature of LRMC Employee validating identity	Department
_____	_____
Signature of LRMC Employee Releasing PHI	Date PHI was released

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ACCT#: