## **AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

MEDICAL RECORD NUMBER:			DATE:			
RELATIONSHIP TO PATIENT: <i>Patient Information</i>	🗆 SELF 🔲 PAF	RENT 🗌 LEGAL	guardian 🗌	OTHER:		
Last Name		First	MI	Date	of Birth	
Address	City	State	Zip	() Phone		
HEREBY AUTHORIZES						
LAC+USC Medical Cente	r l⊏	Bancho Los Ar	igos National R	ehabilitation Cen	ter	
Olive View Medical Center		High Desert Health System				
Harbor-UCLA Medical Ce	i	MLK Jr. Outpat				
CHC/Health Center:						
Other:						
Facility Name	Street Add	ress	City	State	Zip Code	
To Release Protected Health Information To:						
Name of Facility/Health Care Provider/Pla	an/Other	Street Ac	dress			
City		State		Zip C	ode	
for the time period beginning,, and ending Date Date Date EXPIRATION DATE: This authorization is valid until the following date: / / 20						
PLEASE CHECK ALL APPRO			ISOLOSED			
Discharge Summary	JI IIIAI L DOALO.		ntal Illness or N	Mental Health Ass	eeement	
$\square$ History and Physical						
	· · ·					
	Consultation					
	Operative Report					
	Radiology Report					
Radiology Films						
Laboratory / Diagnostic T	ests	🗌 Su	mmary of Medi	cal History / Trea	tment	
Medical Progress Notes						
$\Box$ Other (Please Specify):						
			MRUN			
			NAME			
			DOB/GENDER			
					AND DISCLOSURE	
1   100    11    110    11     11    11    11     11    11    11    11    11    11    11    11	FILE IN MEDICAL RECO	RD	PAGE 1 OF 2		HS1015 (11-14)	

## 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:

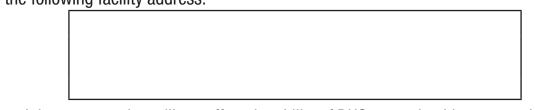
**Right to Receive a Copy of This Authorization** –I understand that if I sign this authorization, I will be provided with a signed copy of the form.

**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	y to do so:
	Date: / /
Witness:	_ Print Name:
<b>Right to Revoke This Authorization</b> – Lunderstand that I have th	he right to revoke this Authorization at any time

**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.

<b>REVOCATION OF AUTHORIZATION</b>	
Signature of Patient/Legal Representative:	
	MRUN
If signed by other than patient, state relationship and authority	
to do so:	NAME
	DOB/GENDER

