

MR: _____

Copy Fees: \$ _____

**AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION**

Patient Name: _____
Last First Middle

Home Address: _____
Street

City State Zip

Home Telephone: _____ DOB: _____

RECIPIENT: Name of person or class of persons to whom Redlands Community Hospital may disclose my health information:

Name: _____

ADDRESS: Address of the recipient or where my health information should be delivered:

Street

City State Zip

TERM: This Authorization will expire on:

The _____ of _____, 20_____.

If no date specified, authorization will expire 6 months from the date signed.

I would prefer to:

- Pick-up or view the Requested Information
- Have the Requested Information mailed

Specify date(s) of service requested or event: _____



Please Note: Redlands Community Hospital may charge you a reasonable fee for making copies of your protected health information at **a charge of 25 cents per page.**

Please check appropriate box(s):

<input type="checkbox"/> Face Sheet	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Laboratory Tests	<input type="checkbox"/> Physician Orders
<input type="checkbox"/> Emergency Room Report	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Medications
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Cardiology Reports	<input type="checkbox"/> Labor/Delivery summary
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Special test/therapy	<input type="checkbox"/> Nurses Notes
<input type="checkbox"/> Operation Reports	<input type="checkbox"/> Rhythm Strips	<input type="checkbox"/> Other: _____

Highly Confidential PHI will not be released without specific consent

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:

<input type="checkbox"/>	_____ Mental Illness: (Physician approval prior to release)
<input type="checkbox"/>	_____ Developmental Disability
<input type="checkbox"/>	_____ Psychotherapy Notes: (Physician approval prior to release)
<input type="checkbox"/>	_____ Communicable Disease
<input type="checkbox"/>	_____ Sexual Assault
<input type="checkbox"/>	_____ Genetic Testing
<input type="checkbox"/>	_____ Domestic Abuse
<input type="checkbox"/>	_____ Child Abuse or Neglect
<input type="checkbox"/>	_____ Adult Abuse
<input type="checkbox"/>	_____ Substance Abuse: Prevention or Treatment
<input type="checkbox"/>	_____ HIV/AIDS: Testing, Diagnosis, or Treatment (regardless of result)

* **PURPOSE:** I authorize Redlands Community Hospital 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: "**Personal**" is sufficient if the Patient is initiating this authorization:



I understand that once Redlands Community Hospital discloses my health information to the recipient, Redlands Community Hospital cannot guarantee that the recipient will not re-disclose 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 I may at any time make a written request to Redlands Community Hospital to inspect and/or obtain a copy of my health information, and that Redlands Community Hospital 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 Redlands Community Hospital; except, however, if my treatment at Redlands Community Hospital is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Redlands Community Hospital may refuse to treat me if I do.

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 Redlands Community Hospital 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 Redlands Community Hospital at the address listed below. The revocation will be effective immediately upon Redlands Community Hospital receipt of my written notice, except that the revocation will not have any effect on any action taken by Redlands Community Hospital in reliance on this Authorization before it received my written notice of revocation.

By mail: Redlands Community Hospital
Director Health Information Management
350 Terracina Blvd.
Redlands, CA 92373

By telephone: (909) 335-5602

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 health information. By my signature below, I hereby, knowingly and voluntarily, authorize Redlands Community Hospital to use or disclose my 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: _____

Description of Authority: _____

Date: _____

