Redlands Community Hospital

MR:____________________

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: ____

Physician Phone: ____________________ Physician Fax: ____________________

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 the Requested Information
- ☐ Have the Requested Information mailed

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

MR:______________

Please check appropriate box(s):

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**.

__Face Sheet	__Pathology Reports	__Progress Notes
__Discharge Summary	__Laboratory Tests	__Physician Orders
__Emergency Room Report	__Radiology Reports	__Medications
__History and Physical	__Cardiology Reports	__Labor/Delivery summary
__Consultation Reports	__Special test/therapy	__Nurses Notes
__Operation Reports	__Rhythm Strips	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:

☐ ______________________________Mental Illness:
☐ ______________________________Developmental Disability:
☐ ______________________________Psychotherapy Notes:
☐ ______________________________Communicable Disease:
☐ ______________________________Sexual Assault:
☐ ______________________________Child Abuse or Neglect:
☐ ______________________________Genetic Testing:
☐ ______________________________Domestic Abuse:
☐ ______________________________Child Abuse or Neglect:
☐ ______________________________Adult Abuse:
☐ ______________________________Substance Abuse: Prevention or Treatment
☐ ______________________________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 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: ________________