Dignity Health.
Northridge Hospital
Medical Center

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested many invalidate this authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient: _____ Date of Birth: _____

Other Names: _____ Phone Number: _____

Medical Record or Account#: _____
(Hospital use only)

I AUTHORIZE: ***NORTHRIDGE HOSPITAL MEDICAL CENTER***
(Facility or Provider)

TO DISCLOSE TO: _____
(Persons/Organizations Authorized to *Receive* Information)

☐ PICK UP ☐ FAX ☐ MAIL

Address: _____
(street, city, state and zip code)

Phone: _____ Fax: _____

☐ **ALL RECORDS** regarding my treatment, hospitalization and outpatient care. (A separate authorization is required to authorize the use or disclosure of psychotherapy notes or research health information.)

I further specifically authorize disclosure of the following records (initial applicable lines below):

_____ Mental health or developmental disability treatment records (excludes "psychotherapy notes")

_____ Substance abuse treatment records

_____ HIV test results (This authorizes disclosure of laboratory test results only. Note that your records may include information concerning your HIV status even if you do not check this box.)

☐ **ONLY THE FOLLOWING RECORDS** or types of health information on the date(s) of treatment as specified:

☐ *Consultation Reports* ☐ *Emergency Department Reports* ☐ *Laboratory Tests*
☐ *Discharge Summary* ☐ *History and Physical* ☐ *Procedure Reports*
☐ *Progress Reports* ☐ *X-Ray (Radiology) Reports*
☐ *Other:* _____
☐ *Dates:* _____

PURPOSE: The purpose and limitations (if any) of the requested use or disclosure is:

☐ Patient request; ***OR***

☐ Other: _____

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified: _____
(insert date)

MY RIGHTS:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: *Northridge Hospital 18300 Roscoe Blvd., Northridge, CA 91328*. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. In some cases, such re-disclosure is not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

SIGNATURE: _____ Date: _____
(Patient or Personal Representative)

_____ _____
Print Name of Personal Representative Relationship to Patient

Patient/Representative Identification Verified. *Initials:* _____ *Dept:* _____

Note: If the **substance abuse treatment** information is protected by federal confidentiality rules (42 C.F.R. part 2) the following prohibition of re-disclosure statements must be provided to the recipient of the information:

The federal rules prohibit you from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.