AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(70.8.004)

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

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient: _____ Date of Birth: _____

Other Names Used: _____ Telephone #: _____

Medical Record or Account #: _____
(Hospital Use Only)

I AUTHORIZE: _____
(Facility or Other Provider)

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

at the following address: _____
(Street, City, State and Zip Code)

the following information contained in the records specified below (check box and 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 <u>even</u> if you do not initial this line.)**

❑ **THE FOLLOWING RECORDS (Not Applicable for Online Patient Center)** specific types of health information, or records for the date(s) of treatment as specified [check applicable box(es)]:

☐ Procedure Reports	☐ Emergency Room Records	☐ Consultation Reports
☐ History & Physical	☐ Progress Notes	☐ Discharge Summary
☐ Laboratory Tests	☐ X-ray Reports	☐ Billing Records
☐ Clinical Summary	☐ Continuity of Care Document	

☐ Date(s): _____

☐ Other: _____

❑ **ALL RECORDS** (**Not Applicable for Online Patient Center**) regarding my treatment, hospitalization, and outpatient care.

Note: A separate authorization is required for the use or disclosure of psychotherapy notes or research health information.

❑ **ONLINE PATIENT CENTER / PATIENT PORTAL**

Email Address: _____

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

☐ At the request of the patient or personal representative; ***OR***

☐ Other: _____

EXPIRATION:

1. **MEDICAL RECORD REQUESTS (Not Applicable for Online Patient Center):** This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified here: _____
   (Insert Date)
2. **ONLINE PATIENT CENTER/PATIENT PORTAL:** This authorization for disclosure through the Online Patient Center will be effective for 10 years or until revoked in accord with the instructions below under the heading of MY RIGHTS.

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: **Mercy Medical Center Redding, Health Information Department, 2175 Rosaline Avenue, Redding, CA 96001**. 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. Such re-disclosure is in some cases 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:

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

Billing Help Line
Dignity Health / HealthPort
(888) 488-7667
(916) 861-1102

Patient Portal Help Line
(877) 621-8014
patientcenterstaff@dignityhealth.org

Patient Label