

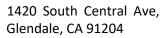
1420 South Central Ave, Glendale, CA 91204

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.

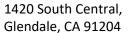
## PATIENT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient:	Date of B	3irth:	
Other Names Used:	Teleph	one Number:	
authorize:	GLENDALE MEMOR	IAL HOSPITAL	
	(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 initia 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 initial this line.)			
<b>THE FOLLOWING RECORDS,</b> specific types of health information, or records for the date(s) of treatment as specified [check applicable box(es)]:			
☐ Itemized Billing R ☐ Complete Health F ☐ History and Physic ☐ Consultation Reco	Record(s) cal	<ul><li>Emergency Room Records</li><li>Progress Notes</li><li>Laboratory Tests</li><li>Radiology Reports</li></ul>	





☐ Dates of Service (Please specify date r	ange)
• • • • • • • • • • • • • • • • • • • •	nt, hospitalization, and outpatient care. A he use and disclosure of psychotherapy
PURPOSE: The purpose and limitations (i	f any) of the requested use or disclosure is
<ul><li>AT the request of the patient or persor</li><li>Other:</li></ul>	•
EXPIRATION: This authorization will autor of execution unless a different end date is	matically expire one (1) year from the date specified:
	(Insert date)
<ul> <li>I may revoke this authorization at any submit it to the following address: revocation will take effect upon receive acted in reliance upon this auth</li> <li>I have a right to receive a copy of this linformation disclosed pursuant to this authorization.</li> </ul>	y time, but I must do so in writing and My pt, except to the extent that others orization. s authorization.
recipient. Such re-disclosure is in some case no longer be protected by federal confidentia the disclosure of substance abuse information disclosing the information under 42 C.F.R. p	es not protected by California law and may ality law (HIPAA). If this authorization is for on, the recipient may be prohibited from
SIGNATURE:	Date:
SIGNATURE: (Patient or personal represen	tative)
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 the recipient 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.