Dignity Health
Northridge Hospital Medical Center
18300 Roscoe Boulevard, Northridge, CA. 91328

Authorization for Use or Disclosure of Protected Health Information

I, _____, **[Print Name of Individual (i.e., patient, resident or client)]** hereby authorize _____ **[Northridge Hospital Medical Center]** to use and disclose the protected health information described below for the following patient:

Patient Name: _____

DOB: _____Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

I authorize the following person(s) or organization to receive the information:

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

The following individually identifiable health information may be used and/or disclosed:

Below are the most frequently requested documents. This does not constitute your entire medical record, which you have the right to request. * Check (✓) all that apply:

- ☐ Abstract (Includes[1])
- ☐ Discharge Summary /Final Diagnosis[1]
- ☐ History and Physical Records[1]
- ☐ Consultation Reports[1]
- ☐ Operations and Procedures[1]
- ☐ Results of Diagnostic Testing[1]
- ☐ Emergency Room Records
- ☐ Lab Reports
- ☐ Immunization (shot) Record
- ☐ Radiology (for example: X-Ray) Reports
- ☐ Other Diagnostic Reports
- ☐ Diagnostic Images (Prepped by Radiology Dept)
- ☐ Physical Therapy Notes
- ☐ Physician Notes
- ☐ Medication List
- ☐ Itemized Bill
- ☐ Demand Bill
- ☐ Other*: _____

_____

_____

_____

Dates of treatment to be released: From: _____ To: _____

Reason or purpose for the use and/or disclosure of the information:

_____

_____

I request the format of release to be sent by:

- ☐ Electronic – Portal address: _____
- ☐ Electronic - Email address: _____

  If email has been selected, email will be sent secured unless otherwise requested. If requesting unsecured email, I understand that unsecured email may place my PHI at risk and accept the risk of sending my PHI via an unsecured method.

  _____**Initial here if requesting unsecured email**.
- ☐ Paper Mail to Address: _____
- ☐ Other (USB, CD, pick-up, etc.) Describe: _____

I understand this authorization allows for the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions will be included unless I indicate otherwise. **I DO NOT WANT** the following information disclosed (as defined by applicable state and federal law):

- ☐ Alcohol/Drug/Substance Use Disorder
- ☐ HIV test results only (notes concerning HIV status will still be released even if initialed/checked)
- ☐ Mental Health/Developmental Disabilities

Prohibition on Conditioning of Authorization: I understand that I have a right not to sign the authorization. The healthcare provider will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

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Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of my health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization's effective date is from the date of signature and will expire upon the date or event entered here: _____ Expiration date or event cannot exceed one year unless otherwise specified by the person signing the authorization.

Revocation: I understand that I may revoke this authorization at any time by notifying the facility in writing by sending a letter to the Facility/Clinic/Entity specified on this release or by completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that were taken before the revocation letter was received. I understand that the facility cannot rescind disclosures it has already made and may use my health information as necessary to bill and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding, controlling, and I understand that they take precedence over statements made in the Facility's Notice of Privacy Practices.

I understand a fee may be charged for copies of my medical record.

I understand I have been provided the opportunity to receive a copy of this authorization.

Signature of Patient or Guardian: _____

Print Name: _____ **Date:** _____

If you are the Personal Representative of the Patient:

Signature of Personal Representative: _____

Print Name: _____ **Date:** _____

Authority or Relationship to Patient: _____

(Please include copies of any documents that establish Personal Representation such as Power of Attorney document, Guardianship papers, Executor of Estate or Administrator of will documents.)

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