Dignity Health.
St. Bernardine Medical Center

2101 N. Waterman Ave, San Bernardino, CA 92404

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 Birth:_____

Other Names Used:_____Telephone Number:_____

I authorize: St. Bernardine Medical Center
(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 even if you do not initial this line.)**

THE FOLLOWING RECORDS, specific types of health information, or records for the date(s) of treatment as specified [check applicable box(es)]:

- ☐ Itemized Billing Records
- ☐ Complete Health Record(s)
- ☐ History and Physical
- ☐ Consultation Record
- ☐ Emergency Room Records
- ☐ Progress Notes
- ☐ Laboratory Tests
- ☐ Radiology Reports

☐ Dates of Service *(Please specify date range)*_____

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

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: 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:_____. 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:
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.