St. John's Regional Medical Center
1600 North Rose Avenue
Oxnard, CA 93030
direct (805) 988-2500

St. John's Hospital Camarillo
2309 Antonio Avenue
Camarillo, CA 93010
direct (805) 389-5800

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 may invalidate this authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient:_____Date of Birth:_____

Other Names Used: _____ Telephone Number:_____

Medical Record #:_____(Hospital use only)

I AUTHORIZE : ☐ St. John's Regional Medical Center ☐ Other: _____
☐ St. John's Hospital Camarillo

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):

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

- ❑ Laboratory Tests
- ❑ X-ray Reports
- ❑ Discharge Summary
- ❑ Consultations
- ❑ Emergency Room Reports
- ❑ History and Physical Report
- ❑ Procedure Reports
- ❑ Medications
- ❑ Progress Notes
- ❑ Pathology Slides
- ❑ Billing Records
- ❑ Date(s):_____
- ❑ Other:_____

❑ **ALL RECORDS** regarding my treatment, hospitalization, and outpatient care.

A separate authorization is required for the use or 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:_____

IDENTIFY HOW YOU WOULD LIKE TO ACCESS THE HEALTH INFORMATION:

☐ Paper ☐ Electronic: CD

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:

  - St. John's Regional Medical Center: 1600 N Rose Avenue, Oxnard, CA 93030, Attention: Health Information Management Dept., Fax: 805-981-4428 or

  - St. John's Hospital Camarillo: 2309 Antonio Ave, Camarillo, CA 93010, Attention: Health Information Management Dept., Fax: 805-389-6066

  My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon 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:_____

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dignityhealth.org/stjohnsregional
dignityhealth.org/stjohnscamarillo