Authorization For Use Or Disclosure of Health Information

Failure to provide all information may invalidate this authorization

**** Proper Legal Identification Required****

Authorization for: Copies of Health Information ❒ Paper ❒ Electronic ❒ Other(specify)_____

Patient Information

Patient's Name: _____ MRN:_____
(Last) (Middle Initial) (First)
Date of Birth:(___/____/_____)Telephone: (___)_____−_____ Email: _____
Address: _____
City: _____State:_____Zip:_____

Release To Request From

I authorize Pomona Valley Hospital Medical Center to Release/ Request Health Information

Release To: _____
Request From: _____
Person/ Organization: _____
Address: _____
City/State/Zip: _____
Telephone: (____)_____−_____ Fax: (____)_____−_____

Purpose

For the following:
__ Continuing Care
__ Insurance
__ Legal
__ Personal Use
__ Other:
_____
_____
_____

Information to Release

Treatment Dates:_____

❒ Billing Record
❒ Cardiology Report
❒ Consultation Report
❒ Discharge Summary
❒ Emergency Record
❒ History and Physical Report
❒ Laboratory Report (Specify test & date)
❒ Operative Report
❒ Other (Please Specify): _____
❒ Outpatient/Clinic Record
❒ Pathology Report
❒ Radiology Images CD
❒ Radiology Report (Add date above)

❒ Complete Medical Record

State/Federal Laws require specific authorization to release the following types of information:
❒ Mental Health
❒ Alcohol/Drug Abuse
❒ HIV Test Results

A separate authorization is required for psychotherapy notes.

Fees

Based on California Evidence Code Sections 1560−1567 Fees may be charged for medical record copies.

Health Information Management Department
Release of Information
1798 N. Garey Ave. Pomona CA 91767
Tel: 909−865−9142
Fax: 909−469−2141
Email: group.him.roi@pvhmc.org

POMONA VALLEY HOSPITAL MEDICAL CENTER

AUTHORIZATION TO USE/DISCLOSE (RELEASE) HEALTH INFORMATION

HIM004 34429_p1 (2/21)

Delivery Instructions	❒ Mail records directly to person or organization specified ❒ Call Requestor when records are ready for pick up I authorize _____ to pick up my Health Information copies. Relationship to patient: _____ Authorized person must have legal ID ❒ Email: _____ ❒ Other: _____
Notice of Rights	I understand that: 1. If I refuse to sign this authorization my refusal will not affect my ability to obtain treatment. 2. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure. 3. I may revoke this authorization at any time, but I must do so in writing and signed by me or on behalf of me and submitted to: Pomona Valley Hospital Medical Center ATTN: Health Information Management Department, 1798 N. Garey Ave. Pomona. CA 91767. 4. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation. 5. I have a right to receive a copy of this authorization. 6. Information disclosed pursuant to this authorization could be re−disclosed by the recipient and may no longer be protected by Federal Confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
Expiration	Without my written revocation, this authorization will automatically expire upon the completion of the disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified: _____
Signature	Signature: _____ Date: _____ *(Patient, Power of Attorney for Healthcare or Legal Representative)* Print Name:_____ Legal Representative Relationship: _____
ROI Only	Released by Signature: _____ Date:_____ Print Name: _____ ❒ Authorized ❒ Not Authorized ❒ Patient not found ❒ Other: _____

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AUTHORIZATION TO USE/DISCLOSE (RELEASE) HEALTH INFORMATION

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