Completion of this document authorizes the use and disclosure of health information about you. Failure to provide all information requested may invalidate this authorization.

PATIENT IDENTIFYING INFORMATION

Patient's Name_____

Date of Birth_____ Last 4 Digits of SSN: XXX−XX−_____

eMail_____ retype eMail_____

The following individual or organization is authorized to receive/review the above named patient's health records. I understand there may be circumstances that would allow the Hospital to receive a fee in exchange for disclosing the information requested on this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize **Pomona Valley Hospital Medical Center** to release to:

_____

(Persons/Organization authorized to receive the information)

_____

(Address − Street, City, State, Zip Code, Phone Number)

The following information (including any dates):

☐ All health information pertaining to my medical history, mental or physical condition and treatment received (fees may apply)

OR

☐ Only the following records or types of health information (including any dates)

- ☐ Medical Records
- ☐ Physical Therapy
- ☐ Laboratory/Pathology Reports
- ☐ Radiology Reports/Images
- ☐ Cardiology
- ☐ Neurology/Sleep Studies
- ☐ Other _____

Specify Dates of Treatment: _____

I understand that the information in my health record may include information related to sexually transmitted disease(s) (STDs), AIDS or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
Required Initial _____

I specifically authorize release of the following information (check as appropriate)

- ☐ Mental health treatment information (*initial*) _____
- ☐ HIV test results (*initial*) _____
- ☐ Alcohol/drug/treatment information (*initial*) _____

PURPOSE

Purpose of requested use or disclosure: ☐ Personal Request ☐ Other: Specify: _____

Limitations, if any: _____

This authorization expires on (date or event):_____

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 inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- 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.
- My revocation will take effect upon receipt, except to the extent that the Hospital or others have acted in reliance upon this authorization. For further information, please see Hospital's Notice of Privacy Practices.
- I have a right to receive a copy of this authorization. I acknowledge that this Authorization was filled out completely when I signed the Authorization.
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases permitted by California law 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.

SIGNATURE

Date: _____ Signature: _____

(*Patient/Legal Representative)*

Print Name: _____

(Legal Representative) − Please include supporting documentation

If signed by a person other than the patient, indicate relationship: _____

Verified by: _____ Date: _____ Identification Verified: ☐ Yes ☐ No