# Community Memorial Health System

## Authorization for Use or Disclosure of Health Information

Patient's Name:________________________ Birth Date:__________ MR#: ________ Bill#: ________

Address: ________________________ City:______________ State:______ Zip Code: __________

Phone(s): ______________________________________________

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.

**Failure to provide all information requested may invalidate this authorization.**

### NOTICE OF RIGHTS AND OTHER INFORMATION

1. I understand that this authorization is voluntary.
2. I may refuse to sign this authorization.
3. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization. I understand the Notice of Privacy Practices provides instruction should I choose to revoke my authorization.
4. I have a right to receive a copy of this authorization.
5. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
6. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might 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.
7. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
8. If this box ☐ is checked, the requestor will receive compensation for the use or disclosure of my information.
9. I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to (address stamp):

I understand I have the right to receive a copy of this authorization. (Civ. Code § 56.12)

I hereby authorize: ______________________________________________

(NAME OF HOSPITAL / CENTER FOR FAMILY HEALTH)

CFH request; fax to:______________________________________________

to release to:______________________________________________

(PERSONS / ORGANIZATIONS AUTHORIZED TO RECEIVE THE INFORMATION)

Address: ________________________ City:______________ State:______ Zip Code:__________

**PLEASE SEE BACK FOR MORE INFORMATION**

*Community Memorial Hospital • Medical Records / Health Information Department • 805/652-5047 • Fax 805/652-5649*
*Ojai Valley Community Hospital • Medical Records / Health Information Department • 805/640-2215 • Fax 805/640-1649*
*Centers for Family Health • Medical Records / Health Information Department • 805/652-5047 • Fax 805/652-5649*

Community Memorial Health System

# Authorization for Use or Disclosure of Health Information

This authorization applies to the following information (select from the following):

- ☐ Discharge summary
- ☐ H&P/consult
- ☐ HIV test results
- ☐ Lab
- ☐ Operative report
- ☐ Alcohol/drug treatment
- ☐ Itemized billing statement
- ☐ Entire medical record
- ☐ ER record
- ☐ X-ray report
- ☐ Mental health treatment information
- ☐ X-ray images on CD
- ☐ Progress notes /Doctors orders
- ☐ Pathology report
- ☐ Other: ____________________

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

## PURPOSE

Description of each purpose of request use or disclosure: ____________________

## EXPIRATION

This authorization expires (insert date): ____________________

This authorization expires one (1) year from date signed below unless a specified date is documented above.

**After you have filled out this form, please print it and bring it to Medical Records at CMH to complete the request process.**

## SIGNATURE

Patient / Representative / Spouse / Financially Responsible Party: ____________________

Date: __________ Time: __________ A.M. / P.M.

If signed by someone other than the patient, state your legal relationship: ____________________

☐ ID checked

I hereby authorize ____________________ to pick up my records.

☐ ID checked

Hospital representative processing request: ____________________

Date: ____________________

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