AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION

Patient Name: ______________________________ Date of Birth: _________________

Address: ______________________________

City, State, Zip: ______________________________

DISCLOSURE STATEMENT

I hereby authorize:

☐ Southwest Healthcare System (includes Rancho Springs & Inland Valley Medical Centers)

☐ Temecula Valley Hospital

☐ Other: ____

To release protected health information to the following person or entity:

Entity or Person: ____________________ Contact Name: ________________________

Address: ____________________ Telephone: ________________________

City, State, Zip: ____________________

HEALTH INFORMATION TO BE RELEASED

☐ Pertinent Information for Continuing Care

☐ History & Physical Exams

☐ Laboratory Reports

☐ Operative Reports

☐ Pathology Reports

☐ Billing Statements

☐ Radiology & Other Imaging Diagnostic Reports

☐ Images (X-rays, MRI, CT, etc ...)

☐ Consultation Reports

☐ Discharge Instructions

☐ EKG/ECHO

☐ ER Record

☐ Other: ____

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

☐ Alcohol or drug treatment information ☐ HIV test results ☐ Mental health treatment information (other than psychotherapy notes)

REQUESTED SERVICE DATES

Please indicate the date(s) and/or time period for the information selected above:

☐ Most Recent Visit ☐ Date(s): ________________

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT IDENTIFICATION

RI0020

INLAND VALLEY MEDICAL CENTER
RANCHO SPRINGS MEDICAL CENTER
TEMECULA VALLEY HOSPITAL

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PURPOSE OF RELEASE

Please indicate the purpose for this release (check one or more):

☐ Continuing Care ☐ Patient Copy ☐ Other: ______________________________

INFORMATION DELIVERY

How would you like to receive the requested information?

☐ U.S. Mail

☐ Faxed to doctor's office or medical facility
Fax: __________________________________

☐ Pick Up Centralized Release of Information Department
25485 Medical Center Dr., Suite 106 Murrieta, CA 92562,
Tel: (951) 696-6013

☐ Other: ____

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 have a right to receive a copy of this authorization. Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited 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 unless such disclosure is specifically required or permitted by law.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address 25500 Medical Center Drive Murrieta, CA 92562. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

EXPIRATION

Unless, otherwise revoked, this Authorization expires ____________ (insert date). If no date is indicated, it will expire upon its completion or 12 Months from date of signature, whichever comes first.

SIGNATURE

Signature: ______________________ Date: ________ Time: ______ AM/PM

Printed Name: ______________________ Telephone: ______________________

Relationship: ______________________ (If not patient)

Completed at time of record pickup:

Record picked up by:

Signature: ______________________ Date: ________ Time: ______ AM/PM

Printed Name: ______________________

Relationship: ______________________ (If not patient)

ID Type: ______________________ ID Number: ______________________

ID Verified by: ______________________

For Office Use Only

Records released from

- ☐ Medical Records
- ☐ Laboratory
- ☐ Radiology
- ☐ Emergency Department
- ☐ Nursing Unit, Unit Name: ______________________
- ☐ Other: ______________________

ID Type: ______________________ ID Number: ______________________

Witness Signature: ______________________ Date: ________ Time: ______ AM/PM

Witness Printed Name: ______________________

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT IDENTIFICATION

RI0020

INLAND VALLEY MEDICAL CENTER
RANCHO SPRINGS MEDICAL CENTER
TEMECULA VALLEY HOSPITAL