

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 Radiology & Other Imaging Consultation Reports

Laboratory Reports Diagnostic Reports Discharge Instructions

Operative Reports Images EKG/ECHO

Pathology Reports (X-rays, MRI, CT, etc ...) ER Record

Billing Statements

Other: _____

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

Alcohol or drug treatment HIV test results Mental health treatment information
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 208 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.

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

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