AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Information (required):

First Name: _____ **Last Name:** _____
Date of Birth: _____ **Phone Number:** _____ **E-Mail:** _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____

I hereby authorize Anaheim Community Hospital, 3350 W. Ball Road, Anaheim, CA 92804, to release my protected health information to (required):

☐ Self (same as above) ☐ Provider ☐ Other: _____		
Name of Hospital/Clinic/Person:		
Address:		
Phone:	Fax:	E-mail:

Delivery Instructions (required, please select one):

☐ Mail ☐ Pick Up (photo ID REQUIRED) ☐ Fax ☐ E-mail: _____

Health Information to be released (required):

Please send records from the following date range: from _____ to _____

☐ Pertinent information **(This is what most patients and physicians need)**. Discharge Summary, History and Physical, Psychiatric Evaluation, Consultations, Operative Reports, Labs, Radiology Reports, EEG, EMG, EKG, and Pathology Reports.

☐ Billing Statement	☐ Discharge Summary	☐ History & Physical Exams
☐ Psychiatric Evaluation	☐ Progress Notes	☐ Lab Report
☐ Radiology Reports	☐ Radiology Imaging	☐ Operative Reports
☐ EKG	☐ Pathology Reports	☐ Consultations

☐ Other: _____

☐ All/Entire Medical Record (Includes pertinent information plus all other documentation in the medical record)
*A fee may be charged

Purpose of requested use or disclosure (required):

☐ Continuity of Care ☐ Personal Use ☐ Legal ☐ Insurance ☐ Other: _____

I expressly authorize the release of the following information (check and initial as appropriate):

☐ Mental health treatment information	Initial if requesting: _____
☐ Psychotherapy notes	Initial if requesting: _____
☐ HIV test results (separate consent is required for each release of HIV test results)	Initial if requesting: _____
☐ Alcohol/drug abuse treatment information	Initial if requesting: _____
☐ Genetic testing information	Initial if requesting: _____
☐ Reproductive health information	Initial if requesting: _____

*If not checked and initialed, the records containing such information can **NOT** be released.

ANAHEIM COMMUNITY HOSPITAL

Patient's Rights:

I understand that I have the following rights concerning this authorization:

1. I understand that information to be released may include information regarding drug or alcohol abuse, psychological or psychiatric impairments, confidential communications, HIV and/or AIDS, physical conditions, or other information that may be privileged or confidential under State and/or Federal law.
2. The recipient of protected health information is prohibited from redisclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. In this case, the recipient may not be required to keep the information confidential, may be subject to redisclosure, and may no longer be protected by federal law.
3. I understand this authorization is voluntary. I may not be required to sign it as a condition of obtaining treatment, payment, or enrollment/eligibility for benefits.
4. I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to **Anaheim Community Hospital, 3350 W. Ball Road, Anaheim, CA 92804**. Such revocation will be effective upon receipt, does not apply to action taken in reliance of this authorization, and will expire on _____or (12) months after the date of signature below.
5. I have the right to receive a copy of this authorization.

Under California law, a healthcare provider may decline to permit inspection or provide copies of mental health records only if the provider determines a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of her/his mental health records. If determined, the health care provider shall make a written record, to be included with the mental health records requested, noting the date of the request and explaining the health care provider's reason for refusing to permit inspection or provide copies of the records, including a description of the specific adverse or detrimental consequences to the patient that the provider anticipates would occur if inspection or copying were permitted. The health care provider shall permit inspection by, or provide copies of the mental health records to, a licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, licensed clinical social worker, or licensed professional clinical counselor designated by the patient's request.

The confidentiality of medical, psychiatric, and substance abuse information is protected by state and federal statutes, rules, and regulations (including California Confidentiality of Medical Information Act; California Administrative Code, Title 22, California Welfare and Institutions Code, Section 5328; and Title 42 of the Code of Federal Regulations). These statutes rules, and regulations require that the patient give informed consent before the release of any health/hospital records or information, except as explicitly provided for within the statutes, rules, and regulations.

Signature of Patient /Legal Representative:	**Date:**
Printed Name:	
Relationship (if other than Patient):	
Witnessed by:	**Date:**

This form may be submitted by mail/email/fax:
Anaheim Community Hospital
Attention: Medical Records Department
3350 W. Ball Road
Anaheim, CA 92804
Phone: (714) 243-9000 | **Fax:** (714) 699-5991
E-Mail: roi@anaheimcommunityhospital.com