Authorization for Use and Disclosure of Health Information

☐ Arrowhead Regional Medical Center (ARMC) 400 N. Pepper Ave., Colton, CA 92324
Phone: 909-580-0060 Fax: 909-658-3799

☐ Fontana Family Health Center (FFHC) 16888 Baseline Ave., Fontana, CA 92336
Phone: 909-347-1654 Fax: 909-347-1749

☐ McKee Family Health Center (MFHC) 1499 E. Highland Ave., San Bernardino, CA 92404
Phone: 909-386-9796 Fax: 909-883-1591

☐ Redlands Family Health Center (RFHC) 800 E. Lugonia Ave., Suite F, Redlands, CA 92374
Phone: 909-798-8414 Fax: 909-798-8425

☐ Westside Family Health Center (WFHC) 850 E. Foothill Blvd., Rialto, CA 92376
Phone: 909-421-9499 Fax: 909-421-9407

Patient Information

Patient Name: _____ SSN: _____

Medical Record Number: _____ DOB: _____

I would prefer to: (check one) ☐ **Have the information mailed**
☐ **Pick-up the requested information *(for ARMC only)***

I hereby authorize Arrowhead Regional Medical Center or Family Health Center as indicated above to:
(check one) ☐ **Disclose my protected health information to:**
☐ **Obtain my protected health information from:**

Name: _____

Full Mailing Address: _____

Purpose: _____

Limitations, if any: _____

Information to Be Disclosed:

I hereby authorize the use or disclosure of the following protected health information:
(Check all that apply)

☐ Discharge Summary ☐ Operation Reports ☐ Radiology Reports ☐ Medications
☐ Emergency Room ☐ Pathology Reports ☐ Billing Information ☐ History and Physical
☐ Laboratory Tests ☐ Immunization ☐ Clinic Notes

☐ Other: _____

Date(s) of Service: _____ to _____

Highly Confidential PHI – By applying my initials next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated, if any such information will be used or disclosed pursuant to this authorization:

____ Mental Health Treatment Information **(Physician approval required prior to release)**
____ Alcohol/Drug Treatment Abuse Information
____ HIV Test Results (regardless of result)
____ I have reviewed and discussed my HIV Test Results with my Care Provider ☐ Yes ☐ No

LGLALARI

I understand that

- I may inspect or copy the protected health information described by this authorization.
- This authorization may be revoked in writing at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
- Information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand that the recipient of my information shall not condition treatment, payment or eligibility for benefits on my providing authorization for the requested use or disclosure and that I may refuse to sign this authorization.
- I understand that recipient of my medical information may have the opportunity to obtain direct or indirect remuneration as a result of the information received by this authorization.
- I have a right to receive a copy of this authorization.

Date and Signature

Date | Signature of patient or representative

Phone | Authority or relationship of representative

Expiration Date: This authorization will expire on [date]:

*(If no date stated, expiration is **six months** from the date it was signed.)*

Note: You will be provided a copy of this authorization if the authorization was requested by and for ARMC, FFHC, MFHC, RFHC or WFHC use.

This authorization form will be utilized for all requests for protected health information (PHI) for purposes other than Treatment, Payment or Operations (TPO). All requests for use or disclosure of patient information (PHI) requiring patient authorization must contain the requirements as listed on this form. This form complies with the Health Insurance Portability and Accountability Act (HIPAA) Final Privacy Rule [45 CFR 160-164] and California state law as applicable.

Office Use Only

☐ ID Verified ☐ On-site Pickup ☐ Mailed - Date: ____ Staff Name_____

☐ Denied Reason (Document all denials)_____