

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) 580-1046
- Fontana Family Health Center (FFHC) 16854 Ivy Ave., Fontana, CA 92335
Phone: (909) 347-1654 Fax: (909) 428-1021
- 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

Mailing Address (Including City, State and Zip Code)

Purpose: _____

INFORMATION TO BE DISCLOSED:

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

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operation Reports | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Radiology Images | <input type="checkbox"/> Billing Information |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Laboratory Tests | <input type="checkbox"/> Immunization | <input type="checkbox"/> Clinic Notes |
| <input type="checkbox"/> 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 Information
- ____ HIV Test Results (regardless of result)



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.

DATE & 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

<input type="checkbox"/> ID Verified	<input type="checkbox"/> On-site Pickup	<input type="checkbox"/> Mailed - Date: _____	Staff Name _____
<input type="checkbox"/> Denied	Reason (Document all denials) _____		

