Prime Healthcare

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

FOR PRIME EMPLOYEES AND THEIR ENROLLED DEPENDENTS USE ONLY

Completion of this document authorizes the disclosure and/or use of health information, about you. Failure to provide all information requested may invalidate this Authorization.

Name of Patient: _____

Date of Birth: _____ SSN: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

USE AND DISCLOSURE OR HEALTH INFORMATION

I hereby authorize _____

to release to: _____ **Covering the period** of healthcare from _____ to _____

Phone #: _____ Fax: _____

(Persons/Organizations authorized to receive the information) (Address- street, city, state, zip code, fax number and/or Email)

_____

The following information:

a. All health information pertaining to my medical history, mental or physical condition and treatment received. – **OR**

Only the following records or types of health information (including any dates):

Discharge Summary	Consultation(s)	All pertinent Lab/X-rays/EKG
History and Physical	Operative Report	Other: _____
Rehab	ER	

b. I specifically authorize release of the following information (initial as appropriate):

Mental health treatment information	STD
HIV test results	Sexual Assault
Alcohol/drug treatment information	Child Abuse/Neglect
Outpatient psychotherapy notes	

PURPOSE

Purpose of requested use of disclosure: patient request; **OR** other

_____

_____

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PATIENT ID

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

EXPIRATION

This authorization expires on _____

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 may revoke this authorization at any time, but I must do so in writing and submit to:

Prime Healthcare
ATTN: Employee Health Plan
3480 East Guasti Road
Ontario, CA 91761
Phone (877) 234-5227 | Fax (909) 235 4414

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization. I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. However, state and federal law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

Options of Electronic Format: According to HITECH section 13405 (e) (1); 42 U.S.C. 17935 (e) (1), you may have your electronic medical records transmitted to you or another entity in electronic format. Please choose which type of format you would like the information to be delivered in and note the receiving entity may not accept records in electronic format:

Burn to CD Paper Email

SIGNATURE

Date: _____ Time: _____am/pm

Signature: _____

(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient. Licensed Psychotherapist's approval or geropsychiatric patient:

_____

_____

Witness: _____

PATIENT ID

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