3ROI

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:	Last First Middle
Home Address:	City State Zip Code
Home Telephone:	
Date of Birth:	

Specify Information to be Disclosed:

☐ Laboratory ☐ History & Physical ☐ Consultation ☐ Radiology ☐ Operative Report
☐ Discharge Summary ☐ Pertinent Info. (Dictated Reports, Lab, EKG)

Dates of Treatment:

By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:

☐ Mental Illness ____________________
☐ Developmental Disability ____________________
☐ Psychotherapy Notes ____________________
☐ HIV/AIDS Testing, Diagnosis, or Treatment (regardless of result) ____________________
☐ HIV Test Result ____________________
☐ Communicable Disease ____________________
☐ Substance Abuse, Prevention or Treatment ____________________
☐ Sexual Assault ____________________
☐ Child Abuse or Neglect ____________________
☐ Genetic Testing ____________________
☐ Domestic Abuse ____________________
☐ Elder Abuse ____________________
☐ Other ____________________

RECIPIENT: **Name of person or class of persons to whom Los Alamitos Medical Center may disclose my health information:**

ADDRESS: **Address of the recipient or where my health information should be delivered:**

Telephone number of the recipient (required):

TERM: **This Authorization will remain in effect:**

☐ From the date of this Authorization until the ________ day of ____________________, 20________.

☐ Until Los Alamitos Medical Center fulfills this request.

☐ Until the following event occurs ____

☐ Other: ____

PURPOSE: I authorize Los Alamitos Medical Center to use or disclose my health information (including the highly confidential I selected above, if any) during the term of this Authorization for the following specific purpose(s): Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization:

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I understand that once Los Alamitos Medical Center discloses my health information to the recipient, Los Alamitos Medical Center cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable law governing the use and disclosure of my health information.

I understand that Los Alamitos Medical Center may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may at any time make a written request to Los Alamitos Medical Center to inspect and/or obtain a copy of my health information, and that Los Alamitos Medical Center will either, within five days for a request to inspect and fifteen days for a request to copy, grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information to provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Los Alamitos Medical Center; except, however, if my treatment at Los Alamitos Medical Center is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Los Alamitos Medical Center may refuse to treat me if I do not sign this Authorization.

I understand that, at any time during which this Authorization is in effect, I may make a written request to receive a copy of this Authorization. Such written request shall be made to Los Alamitos Medical Center's Privacy Office at the address listed below.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Los Alamitos Medical Center's Privacy Office at the address listed below. The revocation will be effective immediately upon Los Alamitos Medical Center's receipt of my written notice, except that the revocation will not have any effect on any action taken by Los Alamitos Medical Center in reliance on this Authorization before it received my written notice of revocation.

I may contact Los Alamitos Medical Center's Privacy Office by mail at 3751 Katella Ave., Los Alamitos, CA 90720, by telephone at 562-799-3576.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Los Alamitos Medical Center to use or disclose my health information in the manner described above.

Signature of Patient ________________ Date ________ Time ________

If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Personal Representative ________________ Description of Authority ________________ Date ________ Time ________

For Internal Use Only: The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records.

Signature of Employee Validating Identity ________________ Date ________ Time ________