Authorization for Use or Disclosure of Protected Health Information

ROI02

I, _____, hereby authorize
[Print Name of Individual (i.e., patient, resident or client)]

☐ Mercy Medical Center Redding ☐ St. Elizabeth Community Hospital
☐ Mercy Medical Center Mt. Shasta

to use and disclose the protected health information described below for the following patient:

Patient Name: _____

DOB: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

I authorize the following person(s) or organization to receive the information:

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

The following individually identifiable health information may be used and/or disclosed:

Below are the most frequently requested documents. This does not constitute your entire medical record, which you have the right to request. * Check (✓) all that apply:

☐ Abstract
☐ Discharge Summary/Final Diagnosis
☐ History and Physical Records
☐ Consultation Reports
☐ Operations and Procedures
☐ Results of Diagnostic Testing
☐ Emergency Room Records
☐ Lab Reports
☐ Immunization (shot) Record
☐ Radiology (for example: X-Ray) Reports
☐ Other Diagnostic Reports
☐ Diagnostic Images (Prepped by Radiology Dept)
☐ Physical Therapy Notes
☐ Physician Notes
☐ Medication List
☐ Itemized Bill
☐ Demand Bill
☐ Other*: _____

Patient Identification / Label

Dignity Health.

Mercy Medical Center Redding | St. Elizabeth Community Hospital | Mercy Medical Center Mt. Shasta

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____

_____

_____

Dates of treatment to be released: From: _____ To: _____

Reason or purpose for the use and/or disclosure of the information:

_____

_____

I request the format of release to be sent by:

- ☐ Electronic – Portal address: _____
- ☐ Electronic – Email address: _____

  If email has been selected, email will be sent secured unless otherwise requested.

  If requesting unsecured email, I understand that unsecured email may place my PHI at risk and accept the risk of sending my PHI via an unsecured method.

  _____ **Initial here if requesting unsecured email**.
- ☐ Paper Mail to Address: _____
- ☐ Other (USB, CD, pick-up, etc.) Describe: _____

I understand this authorization allows for the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions will be included unless I indicate otherwise. **I DO NOT WANT** the following information disclosed (as defined by applicable state and federal law):

- ☐ Alcohol/Drug/Substance Use Disorder
- ☐ HIV test results only
  (notes concerning HIV status will still be released even if initialed/checked)
- ☐ Mental Health/Developmental Disabilities

Prohibition on Conditioning of Authorization: I understand that I have a right not to sign the authorization. The healthcare provider will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of my health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization's effective date is from the date of signature and will expire upon the date or event entered here: _____ Expiration date or event cannot exceed one year unless otherwise specified by the person signing the authorization.

Revocation: I understand that I may revoke this authorization at any time by notifying the facility in writing by sending a letter to the Facility/Clinic/Entity specified on this release or by completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that were taken before the revocation letter was received. I understand that the facility cannot rescind disclosures it has already made and may use my health information as necessary to bill and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding, controlling, and I understand that they take precedence over statements made in the Facility's Notice of Privacy Practices.

I understand a fee may be charged for copies of my medical record.

I understand I have been provided the opportunity to receive a copy of this authorization.

Signature of Patient or Guardian: _____

Print Name: _____ **Date:** _____

If you are the Personal Representative of the Patient:

Signature of Personal Representative: _____

Print Name: _____ **Date:** _____

Authority or Relationship to Patient: _____

(Please include copies of any documents that establish Personal Representation such as Power of Attorney document, Guardianship papers, Executor of Estate or Administrator of will documents.)

Billing Help Line
Dignity Health
(888) 488-7667

Patient Portal Help Line
(844) 274-8497

Patient Identification / Label