

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

\_\_\_\_\_  
Last Name                                      First                                      MI                                      Date of Birth (Mo/D/Yr)                                      Medical Record Number

**HEREBY AUTHORIZES:**

- LAC+USC Medical Center
- Harbor-UCLA Medical Center
- MLK-MACC
- Olive View Medical Center
- High Desert Hospital
- Rancho Los Amigos National Rehabilitation Center
- CHC/Health Center: \_\_\_\_\_
- Other: \_\_\_\_\_

**To Release Protected Health Information To:**

\_\_\_\_\_  
Name of Facility/Health Care Provider/Plan/Other

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City                                      State                                      Zip Code

for the time period beginning, \_\_\_\_\_, and ending, \_\_\_\_\_.

**INFORMATION TO BE DISCLOSED**

**PLEASE CHECK ALL APPROPRIATE BOXES:**

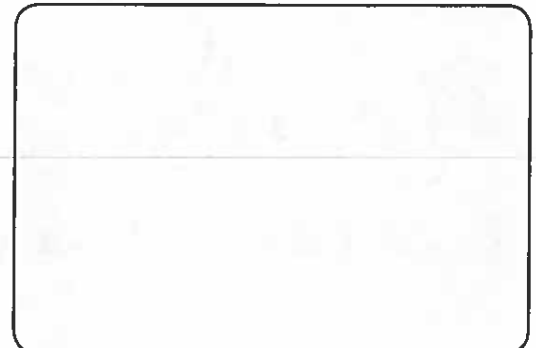
- |   |   |
|---|---|
| <input type="checkbox"/> Summary of Medical History / Treatment     | <input type="checkbox"/> History and Physical   |
| <input type="checkbox"/> Laboratory / Diagnostic Tests              | <input type="checkbox"/> Medical Progress Notes |
| <input type="checkbox"/> Discharge Summary                          | <input type="checkbox"/> Radiology Reports      |
| <input type="checkbox"/> Consultation                               | <input type="checkbox"/> Radiology Images       |
| <input type="checkbox"/> Psychological Testing                      | <input type="checkbox"/> EKG Report             |
| <input type="checkbox"/> HIV/AIDS                                   | <input type="checkbox"/> EEG Report             |
| <input type="checkbox"/> Sexually Transmitted Disease(s)            | <input type="checkbox"/> Operative Report       |
| <input type="checkbox"/> Mental Illness or Mental Health Assessment | <input type="checkbox"/> Pathology Report       |
| <input type="checkbox"/> Drug and/or Alcohol Abuse Treatment.       |   |
| <input type="checkbox"/> Other (Please Specify)                     |   |

**THE PURPOSE OF THE DISCLOSURE - PROVIDE A DESCRIPTION OF THE PURPOSE OF INTENDED USE AND DISCLOSURE**

I understand that health information used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

**EXPIRATION DATE:** This authorization is valid until the following date:

\_\_\_\_/\_\_\_\_/\_\_\_\_



**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

**Right to Receive a Copy of This Authorization** – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

**Right to Revoke This Authorization** – I understand that I have the right to revoke this Authorization at any time by telling DHS in writing. I may use the Revocation of Authorization at the bottom of this form. Mail or deliver the revocation to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I also understand that a revocation will not affect the ability of DHS or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization.

**CONDITIONS:** I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, DHS may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

**I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.**

**Signature Of Patient/Legal Representative:** \_\_\_\_\_

If signed by other than the patient, state relationship and authority to do so:

\_\_\_\_\_

**DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
MONTH DAY YEAR

**WITNESS:** \_\_\_\_\_

**REVOCAION OF AUTHORIZATION**

**Signature Of Patient/Legal Representative:**

\_\_\_\_\_

If signed by other than patient, state relationship and authority to do so:

\_\_\_\_\_

**DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
MONTH DAY YEAR

Name: \_\_\_\_\_ MRUN#: \_\_\_\_\_  
Date: \_\_\_\_\_

**FOR OFFICE USE ONLY**

INFORMATION REQUESTED	DATES
1. ALL RECORDS	
2. DISCHARGE SUMMARY	
3. RADIOLOGY REPORT	
4. RADIOLOGY IMAGES	
5. EKG REPORT	
6. EEG REPORT	
7. PSYCHOLOGICAL TESTING	
8. OPERATIVE REPORT	
9. PATHOLOGY REPORT	
10. PROGRESS NOTES	
11. CONSULTATION	
12. LABORATORY REPORT	
13. OTHER	

SENT BY:	DATE SENT:
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{DHS Facility Name and Address}

