USC Arcadia Hospital
Keck Medicine of USC
300 W. Huntington Drive, Arcadia, CA 91007

DTROI

**HEALTH INFORMATION MANAGEMENT DEPARTMENT**
PHONE#: 626-574-3566 FAX#: 626-898-8855
DL-UAH-HIMROIStaff@med.usc.edu

# AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Pick up ☐ Mail ☐ Fax # ☐ Email to ☐

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

I hereby authorize USC Arcadia Hospital to use or disclose my protected health information as follows:

| PATIENT IDENTIFICATION: | | |
|---|---|---|
| Patient Name: | | MR# |
| Address: | Email: | |
| City: | State: | Zip: |
| Birthdate: | Phone #: | |

| RELEASE INFORMATION TO: | | |
|---|---|---|
| Name: | Phone: | Fax: |
| Address: | Email: | |
| City | State: | Zip: |

**DESCRIPTION OF INFORMATION TO BE RELEASED:**

Specify Date of Service/Admission:

☐ All health information pertaining to the above date(s) of service of my medical history, mental or physical condition and treatment received; and/or

☐ Only the specified types of health information _____

☐ Radiology Films/CD ☐ Pathology Slides ☐ Other:_____

I would like to receive this information on: ☐ Paper ☐ Electronic Format

Limitations of disclosure, if any:

I specifically authorize release of the following information (Initial as appropriate):
☐ AIDS/HIV Test Results ☐ Alcohol/Drug Treatment ☐ Mental Health Treatment

☐ Initial if Not Applicable

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**Patient Name:**_____

| PURPOSE OF MY REQUEST | |
|---|---|
| ☐ Patient | ☐ Other: |

| EXPIRATION |
|---|
| This authorization expires on this specific date: |

**NOTICE OF RIGHTS AND OTHER INFORMATION:**

- I may refuse to sign this authorization. If you do, we will not be able to release your medical records to you or the requestor.
- I may inspect or obtain a copy of the protected health information that I am being asked to release.
- I may revoke this authorization at any time, but I must do so in writing and submit it to USC Arcadia Hospital, 300 West Huntington Drive, Arcadia, CA 91007. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- Neither treatment, payment, nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).
- I have a right to receive a copy of this authorization.

If this box ☐ is checked, the Requestor will receive compensation for the use or disclosure of my information. (Marketing Purposes)

| SIGNATURE: | | |
|---|---|---|
| Signature: | Date: | Time: |
| If not signed by the patient, sign and state your legal relationship to the patient and present appropriate identification and/or documents to support authority for request. | | |

Personal Representative Name: _____

☐ Parent of a minor ☐ Legal Guardian/Conservator ☐ Holder of a Power of Attorney for Health Care ☐ Executor ☐ Other: _____

**OFFICE USE ONLY:**

ID Verified By: Date: Time:

☐ Patient received a copy of this form