PACIFICA HOSPITAL OF THE VALLEY

**AUTHORIZATION FOR RELEASE OF (PHI) PROTECTED HEALTH INFORMATION**

Patient Name:

Birth Date:

SSN (Last Four Digits – Only):

**I authorize ______________________________ to release PHI to:**
**(name of person/ facility which has information)**
**Name of person/ facility to receive PHI:** ____________________

______________________________

**Address:** ______________________________

**City, State & Zip Code:** ______________________________

I would like to: ☐ REQUEST A **PAPER** COPY

***TYPE OF RECORDS***

| ☐ **MEDICAL** | ☐ **MENTAL HEALTH** |
|---|---|

**INFORMATION TO BE RELEASED**

| | | |
|---|---|---|
| ☐ Discharge Summary | ☐ Laboratory Reports | ☐ Emergency Medicine Reports |
| ☐ Pathology Reports | ☐ Operative Reports | ☐ History & Physical Exams |
| ☐ EKG<br>☐ Progress Notes | ☐ Radiology & other Diagnostic Images | ☐ Radiology & other Diagnostic Reports |
| ☐ Drug & Alcohol Abuse Information | ☐ Outpatient Clinic Records | ☐ Genetic Testing Information<br>☐ Psychological/Vocational Test Results<br>☐ HIV/AIDS Test Results<br>☐ HIV/AIDS Treatment Information |
| ☐ Other | | |

SPECIFY DATE/ TIME PERIOD FOR INFORMATION SELECTED ABOVE:

**THE PURPOSE OF THIS RELEASE IS (check one or more)**

☐ At the request of the patient/patient representative

☐ Other (state reason)

Initials of Patient or Legal Representative:____________

PACIFICA HOSPITAL OF THE VALLEY

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## NOTICE

PACIFICA HOSPITAL and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

## MY RIGHTS

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create PHI to provide to a third party.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to the Health Information Management Services, PACIFICA HOSPITAL OF THE VALLEY, 9449 San Fernando Rd., Sun Valley, CA 91352. The revocation will take effect when Pacifica Hospital receives it, except to the extent that Pacifica Hospital Health System or others have already relied on it.
- I am entitled to receive a copy of this Authorization.

## EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires ________________________
(Insert applicable date or event). If no date is indicated, this Authorization will expire on the date of signing this form.

**SIGNATURE**

___________________________________ DATE:____________TIME:__________AM/PM
(Signature of Patient / Legal Representative)

___________________________________          ________________________________
Printed Name                                                  Phone Number (include area code)

__________________________________________________________________________
(If signed by someone other than the patient, indicate relationship to the patient)

___________________________________ DATE:____________TIME:__________AM/PM
(Signature of Witness / Interpreter (only if patient unable to sign)

**PACIFICA HOSPITAL OF THE VALLEY, Release of Information**
**9449 San Fernando Rd. Sun Valley, CA. 91352**
**Fax: 818.252.2473 Phone: 818.252.2225**