1701 Santa Anita Avenue
South El Monte, CA 91733
626-579-7777

AUTHORIZATION FOR PATIENT ACCESS OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date: ____________________________M.R. # or Account #:___________________________________

Patient Name: ___________________________________ AKA/Other Names______________________

Date of Birth:___________________________________ Phone: _______________________________

Address: ____

City/State/Zip____

Covering the period of healthcare from (date)________________to (date)_______________

I authorize Greater El Monte Community Hospital to disclose to:

____

(Persons/Organizations authorized to receive the information.)

____

(At the Address Above) Street, City, State & Zip Code

There may be fees associated with your request. The form in which you access your information may determine the amount of such fees.

A. For Yourself: You would like access to the health information about you as follows: *(Check one).*

- ☐ inspect only
- ☐ copy only *(Fees may apply.)*
- ☐ inspect and copy *(Fees may apply.)*

B. You may obtain the following in lieu of a copy of the medical records:

- ☐ written summary of health information *(Fees may apply.)*

C. Tell us which type of health information you want to release or receive access to: *(Check all that apply):*

- ☐ Complete Health Record(s)
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultation Reports
- ☐ Billing Records
- ☐ Others *(please specify)* ____
- ☐ Emergency Room Records
- ☐ Progress Notes
- ☐ Laboratory Tests
- ☐ X-ray Reports

The following classes of information are protected by special privacy laws and access may be subject to special rules or may be restricted under certain circumstances or access may require consultation with your physician or healthcare provider responsible for your care before release. If you are requesting access to records relating to any of the following, please initial each applicable item to confirm your request.

____Mental health or developmental disability treatment records (excludes "psychotherapy notes") – **To be released upon caregiver's approval. See page 4.**

____Substance abuse treatment records

____**HIV test results (This authorizes disclosure of laboratory test results only.** Note that your records may include information concerning your HIV status even if you do not initial this line.)

All patients' (or personal representative's) request(s) for access to their health information are processed in the order received. Upon the hospital's receipt and review of your request, we will contact you for a time and place when and how you may inspect and/ or obtain a copy of the records requested.

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified:____.
(Insert Date)

MY RIGHTS:

- I may refuse to sign this authorization. My refusal will not affect by ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so **in writing** and submit it to the following address:

  1701 Santa Anita Ave., South El Monte, CA 91733. Attn: Health Information Services

  My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

- I have a right to receive a copy of 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). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

I have read and confirm the terms of access/release stated herein.

Patient Signature/Personal Representative:____

Date:____

Name of Personal Representative (Print):____

Relationship to Patient:____

Phone Number:____

ID Presented:____

Name of Hospital Employee Verifying Signatory Information:

Title_______________________________________Department_________________________________

**********************************Facility Use Only ******************************

[ ] Approved
[ ] Approved subject to the following restrictions
[ ] Denied (Note: Access may only be restricted or denied if you believe that providing access is reasonably likely to endanger the life or physical safety of the patient.)

Restrictions:____
____

FOR PSYCHIATRIC OR MENTAL HEALTH RECORDS

CAREGIVER'S APPROVAL TO RELEASE OF INFORMATION
The undersigned, the physician, licensed psychologist or social worker with a master's degree in social work, who is in charge of the patient ______________________________________ hereby
☐ approves ☐ disapproves the release of information and records to the patient or personal representative specified herein.
(NOTE: If disclosure is disapproved, give reasons below and note any restrictions to the release of records. No approval is required for release to patient's attorney, unless the request is for the use or disclosure of information given in confidence by the patient's family.)

____
____

Signature: ____ Degree: _________________
Print Name: ______________________________________ Telephone: ______________
(physician, psychologist, social worker)
Date: ____

Addressograph

M-1 (2/06)

AUTHORIZATION FOR RELEASE/ACCESS OF PROTECTED HEALTH INFORMATION

Original: Copy: