VALLEY PRESBYTERIAN HOSPITAL

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information	Patient Name: _____ Date of Birth: _____ Address: _____ City, State & Zip Code: _____ Phone: ( ) _____ Email: _____
Release Records to *Where do you want records sent?*	**I authorize Valley Presbyterian to release medical records to:** Name of Hospital/Clinic/Person: _____ Address: _____ City, State & Zip Code: _____ Phone: ( ) _____ Email: _____
Purpose *What is the purpose of this release?*	☐ Continuing care ☐ Insurance ☐ Legal ☐ Personal use ☐ Other (please specify): _____
Health Information to be Released: *What records are being requested?*	Treatment Dates: _____ ☐ Consultation Report ☐ Operative Report ☐ X-ray film/Images ☐ Discharge Summary ☐ Pathology Report ☐ Emergency Record ☐ History and Physical ☐ Progress Note ☐ Entire Medical Record ☐ Laboratory Report ☐ Radiology Report ☐ Billing Record ☐ Other (please specify): _____
Sensitive Information	**Sensitive information will not be released unless specifically authorized below:** ☐ Birth Control ☐ Abortion /Abortion Related Services ☐ Gender Affirming Care ☐ Drug and Alcohol Abuse Results ☐ Genetic Testing Information ☐ HIV/AIDS Test Results ☐ Psychological/Vocational Results
Expiration of Authorization	Unless otherwise revoked, this Authorization expires_____ insert applicable date or event). If no date is indicated this Authorization will expire 12 months after the date signed.
Signature(s)	_____ (Signature of Patient / Legal Representative) Date _____ Signature of Witness (only if patient unable to sign) Date *Note: If acting as a Conservator, Beneficiary, or Power of Attorney, you must furnish a copy of your appointment papers with this authorization.

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Patient Rights

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I understand that I have a right to revoke this authorization at any time.

I understand that revocation must be in writing and presented to the Health Information Management Department.

I understand revocation will not apply to information that has been released in response to an authorization. I understand that revocation will not apply where the law requires Valley Presbyterian Hospital to disclose information to a third party.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I do not need to sign this form to ensure healthcare treatment.

Valley Presbyterian Hospital, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that Valley Presbyterian Hospital will not refuse treatment based on whether or not the patient signs this authorization.

I may contact Valley Presbyterian Hospital, Attn: Privacy Officer, 15107 Vanowen Street, Van Nuys, CA 91405 or by telephone at (818) 782-6600 if I feel that my rights have been violated.

I understand that I have a right to receive a copy of this authorization upon my request.
Copy requested and received: ☐ Yes ☐ No Initials: _____

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information.

By my signature, I hereby, knowingly and voluntarily authorize Valley Presbyterian Hospital to use or disclose my health information in the manner described above