Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____

I authorize _____ to release
(name of person/facility which has information)
Protected Health Information (PHI) to:
Name of person/facility to receive PHI _____

_____

Address _____
City, State and Zip Code _____
Phone _____ Fax _____

TYPE OF RECORDS ☐ Hospital ☐ Office/Clinic visit

Information to be **RELEASED**

☐ Discharge Summary	☐ History and Physical	☐ Emergency Dept. Records
☐ Operative/Procedure Reports	☐ Pathology Reports	☐ Radiology Reports
☐ Radiology and Other Diagnostic Images (X-rays)	☐ EKG/Cardiology Reports	☐ Lab Reports (Specify date for continued coverage _____)
☐ HIV test results	☐ Behavioral Health Information	☐ Drug/Alcohol Information
☐ Entire Record which will include all of the above categories (charge may apply)		
☐ Other-Specify:		

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)_____

DELIVERY METHOD

☐ Mail	☐ Patient Pick-up
☐ Family Member/Personal Representative Pick-up: _____ Name _____ Phone: _____ Relationship: _____	

EISENHOWER MEDICAL CENTER
39000 Bob Hope Dr., Rancho Mirage, CA 92270

HIPAA Authorization

411244 (4/2015)

NOTICE

Eisenhower Medical Center 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, or 3) to determine an entity's obligation to pay a claim.
- I may revoke this authorization at any time, provided I do so in writing and submit it to the Health Information Management, Eisenhower Medical Center, 39000 Bob Hope Drive, Rancho Mirage, CA 92270. The revocation will take effect when EMC receives it, except to the extent that EMC may 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 in six months from the date of your signature.

SIGNATURE

_____ Date _____ Time _____ AM/PM
(Signature of Patient/Legal Representative)

_____ _____
Printed Name Phone Number (include Area Code)

_____
(Relationship to the patient if signed by Legal Representative above)

_____ Date _____ Time _____ AM/PM
Signature of Witness/Interpreter (only if patient unable to sign)

DEPARTMENT SPECIFIC USE

Patient Identification _____ Date sent _____
☐ Mail ☐ Fax ☐ Picked-up ☐ CD/DVD Initials _____

Eisenhower Medical Center
Health Information Management
39000 Bob Hope Drive
Rancho Mirage, CA 92270
Fax: 760-773-2020 Phone: 760-773-1211