

**AUTHORIZATION FOR
 USE OR DISCLOSURE OF PROTECTED
 HEALTH INFORMATION**

I WOULD LIKE TO PICK UP _____

PLEASE MAIL _____

Completion of this document authorizes the use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. **Failure to provide all information requested may invalidate this Authorization.**

I hereby authorize **Torrance Memorial Medical Center** to use or disclose my protected health information as follows:

PATIENT IDENTIFICATION:

Patient Name:		
Social Security Number:	Date of Birth:	** Phone number where we may contact you: ()
** Note: <input type="checkbox"/> O.K. to leave message with detailed information <input type="checkbox"/> Leave message with call back number only		

RELEASE TO:

Persons/Organizations/Patient:	
Name:	
Address:	
City, State, Zip:	Phone no: ()

I REQUEST COPIES OF MY MEDICAL RECORD:

<input type="checkbox"/> For my physician (no charge for copies)	<input type="checkbox"/> For my attorney (there will be a charge)
<input type="checkbox"/> As the patient (Please see note)**	<input type="checkbox"/> Other (there may be a charge)
** Note: The law makes access conditional upon payment of allowable charges	

TYPE OF INFORMATION TO BE RELEASED:

This Authorization applies to the following information (select <i>only one</i> of the following):	
<input type="checkbox"/> All health information pertaining to any medical history, mental or physical condition and treatment received. [Optional] Except:	
<input type="checkbox"/> Only the following records or types of health information (including any dates):	
1.	
2.	

EXPIRATION AND SIGNATURE:

This authorization expires on [insert date]:	<input type="checkbox"/> I would like a copy of this authorization	
Signature: <i>(patient, representative, spouse)</i>	Date:	Time:
If signed by someone other than the patient, state your legal relationship to the patient:		

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 revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered or mailed to the:
 Health Information Management Department
 Torrance Memorial Medical Center
 3330 Lomita Blvd.
 Torrance, CA. 90505
- ◆ My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
- ◆ I have a right to receive a copy of this authorization.
- ◆ Neither treatment, payment, enrollment 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 and might no longer be protected by federal confidentiality law (HIPAA). However, **California** law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is required or permitted by law.
- ◆ I may inspect or obtain a copy of the protected health information that I am being asked to release.

REVOCAION OF REQUEST

I would like to revoke this Authorization for Use or Disclosure of Protected Health Information request.

Signature: (*patient, representative, spouse*)

Date:

Time:

If signed by someone other than the patient, state your legal relationship to the patient:

Torrance Memorial Medical Center Representative
 Signature:

Date:

Time:

OFFICE USE ONLY:

Records received by:

Date:

Time:

Mailed out:

Date:

Time:

HIM Personnel Signature:

Date:

Time: