MR #: ____________________

AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION

Patient Name: ____
Last First Middle

Home Address: ____
Street

____
City State Zip

Home Telephone: ______________________________ DOB: _____________________

RECIPIENT: Name of person or class of persons to whom Olympia Medical Center may disclose my health information: PLEASE CIRCLE ONE

Attorney Doctor DPA Insurance Self Other:____________________

ADDRESS: Address of the recipient or where my health information should be delivered:

____

Street____
City State Zip

I would prefer to:

□ Pick-up or view the Requested Information
OR
□ Have the Requested Information mailed

TERM: **This Authorization will expire on:**

The __________ day of _______________________, 20_________.

* If no date specified it will expire 6 months from the date signed.

Specify date(s) of service requested or event:

____

Please check appropriate box(s) Pertinent, All records or specific report(s) and / or test(s)

☐ **Pertinent Records - Package A**

❒ Discharge Summary ❒ Laboratory Tests ❒ Pathology Reports
❒ History and Physical ❒ Radiology Reports ❒ ER Report
❒ Consultation Reports ❒ Cardiology Reports ❒ Operation Reports
❒ Face Sheet

☐ **All Records -Package A and Package B**

❒ Progress Notes ❒ Special test/therapy ❒ Graphics
❒ Physician Orders ❒ Nurses Notes
❒ Medications ❒ Rhythm Strips

Highly Confidential PHI (Will not be released without specific consent)

By applying a check next to a category of highly confidential information listed below and **signing on the appropriate line after the checked box**, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this authorization:

□ Mental Illness: ____
□ Developmental Disability: ____
□ Psychotherapy Notes: ____
□ Communicable Disease: ____
□ Sexual Assault: ____
□ Child Abuse or Neglect: ____
□ Genetic Testing: ____
□ Domestic Abuse: ____
□ Child Abuse or Neglect: ____
□ Adult Abuse: ____
□ Substance Abuse: ____
(Prevention or Treatment)
□ HIV/AIDS: ____
(Testing, Diagnosis, or Treatment (regardless of result))

**** PURPOSE:*** I authorize Olympia Medical Center to use or disclose my health information (including the highly confidential I selected above, if any) during the term of this

Authorization for the following specific purpose(s): Note: **"at the request of the Patient"** is sufficient if the Patient is initiating this Authorization:

____

I understand that once Olympia Medical Center discloses my health information to the recipient, Olympia Medical Center cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable law governing the use and disclosure of my health information.

I understand that I may at any time make a written request to Olympia Medical Center to inspect and/or obtain a copy of my health information, and that Olympia Medical Center will either, within five days for a request to inspect and fifteen days for a request to copy, grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Olympia Medical Center; except, however, if my treatment at Olympia Medical Center is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Olympia Medical Center may refuse to treat me if I do.

I understand that, at any time during which this Authorization is in effect, I may make a written request to receive a copy of this Authorization. Such written request shall be made to Olympia Medical Center at the address listed below.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Olympia Medical Center at the address listed below.
The revocation will be effective immediately upon Olympia Medical Center's receipt of my written notice, except that the revocation will not have any effect on any action taken by Olympia Medical Center in reliance on this Authorization before it received my written notice of revocation.

I may contact Olympia Medical Center's Privacy Officer

By mail: 5900 West Olympic Blvd., Los Angeles, CA 90036, Attn. Privacy Officer

By telephone: 323-932-5003
By email: omc-privacyofficer@olympiamc.com

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 below, I hereby, knowingly and voluntarily, authorize Olympia Medical Center to use or disclose my health information in the manner described above.

_______________________________________ ___________________________
Signature of Patient Date

If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Personal Representative:___________________________________

Description of Authority: ___________________________________

Date: _____________________

For Internal Use Only: The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records.

____ ___________________
Signature of employee validating identity Date