Completion of this document authorizes the disclosure and use of health information about you. *Failure to provide all information requested* may invalidate this authorization.

Patient's Name: _____
Last First Middle

USE AND DISCLOSURE OF HEALTH INFORMATION

Address: _____
Street City State Zip code

Telephone:_____ **Date of Birth:** _____

E-mail Address: _____

I hereby authorize VPH to release the selected information, including highly confidential information, to be disclosed to:

_____
(Persons/organizations authorized to receive the information)

_____
(Address – street, city, state, zip code)

Specify information to be disclosed:

☐ Complete Medical Record
☐ Specific Information (dictated reports, test results, etc.)
☐ Other (specify): _____

HIGHLY CONFIDENTIAL INFORMATION Not to be disclosed unless initialed below:

☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported) will not be released *unless initialed here* _____.
☐ Chemical Dependency: To include drug, alcohol and substance abuse documentation will not be released *unless initialed here* _____.
☐ Mental Health: Information will not be released *unless initialed here* _____.

Dates of Treatment: _____ to _____
(date) (date)

Purpose of disclosure:

☐ Medical Care ☐ Personal Use ☐ Other (specify): _____

Expiration:

This authorization expires on:_____ *(will expire in six (6) months if left blank)*
(date)

Patient Rights:

I understand that I have a right to revoke this authorization at any time. I understand revocation must be done so in writing and presented to the Medical Records/Health Information Management Department. I understand the revocation will not apply to information that has already been released in response to this 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.

_____ _____

Signature of Patient **Date**

Note: If the patient is a minor or is otherwise unable to sign this authorization, obtain the following signatures:

_____ _____

Signature of authorized personal representative Relationship to patient*

_____ _____

Print authorized personal representative name Date

_____ _____

Witness Signature Date

*Note: If acting as a Conservator, Beneficiary, or Power of Attorney, you must furnish a copy of your appointment papers with this authorization.