AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient: _____ **Other Names Used:** _____

Date of Birth: _____ **Telephone Number:** _____ **Medical Record #** _____

I AUTHORIZE: MVSC Medical Records Dept.
(Facility or Other Provider)

TO DISCLOSE TO: _____
(Person/Organization Authorized to Receive the Information)

at the following address: _____
(street, city, state and zip code)

OR FAX THE FOLLOWING RECORDS, specific types of health information, or records for the date(s) of treatment as specified [check applicable box(es)]:

FAX TO #:
909. 801-8166

- ☐ **Billing Records**
- ☐ **Consultation Reports**
- ☐ **History and Physical**
- ☐ **Laboratory Tests**
- ☒ **Procedure Reports**
- ☐ **Progress Notes**
- ☐ **X-Ray Reports**
- ☐ **Date(s) of Service:** _____
- ☒ **Other:** PATHOLOGY - IF DONE

PURPOSE: The purpose and limitation (if any) of the requested use or disclosure is:

- ☒ **At the request of the patient or personal representative; *OR***
- ☐ **Other:** _____

EXPIRATION: This authorization will automatically expire in one (1) year from the date of execution unless a different end date is specified: 12/31/2025
(insert date)

MY RIGHTS:

- **I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.**
- **I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: Mountain View Surgery Center, 10408 Industrial Circle. Redlands, CA 92374, Attn: Administration. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.**

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPPA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

SIGNATURE: X _____ **DATE:** X _____
(Patient or personal representative)

_____ _____
Print Name of personal representative **Relationship to patient**

Patient/Representative Identification Verified: X **ID#:** _____ ***Initials:*** _____
State issued ID, DL, or Military ID (pictured only)
CA I.D.

Note: If the **substance abuse treatment** information is protected by federal confidentiality rules (42 C.F.R. PART 2) the following prohibition of re-disclosure statements must be provided to the recipient of the information:

The federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person the whom it pertains, or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.