INSTRUCTIONS FOR THE COMPLETION OF AN AUTHORIZATION TO USE/DISCLOSE PROTECTED HEATLH INFORMATION (PHI)

Patient:

1. Enter patient name and date of birth

Send records to:

3. Full name and address of person/agency to which the records are to be sent
4. Complete relationship to patient

How do you want this information released?

5. Mailed, faxed, encrypted email, pick up

Purpose of disclosure / Why do you want this information released:

6. Check the reason as to why records are being requested

What information do you want released:

7. Check specifically what portions of the record you wish to have released

Expiration date:

8. This authorization will only remain in effect until the date specified. You may enter any date you desire. If no date is entered, it will expire in 30 days.

You have a right to receive a copy of this authorization.

9 Patients/parent/legal guardian/conservator signature required
10. Please date the authorization

Who is Authorized to Release Medical Information:

1. For a child/adolescent under the age of 18 years, the legal guardian's signature is required. If the legal guardian is someone other than the child's parents, we will require a copy of the court paperwork identifying the legal guardian.
2. If the child is 12 years of age or older, Title XXII (California State Law [45C.F.R. 164/502(G); Cal Civil Code 56.105 (c)]) requires that the child/adolescent signature as well as the legal guardian signature is required.
3. For adults who have conservators, we will need a copy of the court documents indicating conservatorship.
4. A Court Order may release records directly to the court having jurisdiction over current proceedings, without the patient/legal guardian signature.

When can I expect the copies to be sent?

Upon receipt of a properly executed request, copies will be sent within 15 days from the date received, according to Health & Safety Code 123110(b).

What is the Cost of Medical Records?

****Information can be sent at NO CHARGE to a doctor, therapist or licensed professional ****

1. A request for records for the purpose of: "Continuation of Care/Treatment", i.e. another hospital, physician, clinic or therapist. The copies will be made at no cost to the patient.
2. Records that are requested by the patient for personal use, or any other interested parties for reasons other than continuation of care/treatment; there is a processing fee of $4.00 per ¼ hour and $.25¢ per page.

Payment for records may be made in the form of check or money order,
Payable to: DEL AMO HOSPITAL.

Del Amo Behavioral Health System of Southern California

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFOMRATION
(Substance Abuse/Psychiatric Records)

Failure to provide all information may invalidate this authorization.

Patient Information

Patient Name:_____ MRN: _____
(Last Name) (First Name)
Date of Birth:_____ Phone: _____
Address:_____
City:_____ State:_____ Zip: _____

Release To

AUTHORIZES: Del Amo Hospital 23700 Camino Del Sol, Torrance, Ca 90505

Person / Organization: _____
Address:_____
City / State / Zip: _____
Phone:_____ Fax: _____
Relationship:_____

Purpose

For the following:
___ Continuing Care
___ Insurance
___ Legal
___ Personal Use
___ Other: _____

I **REFUSE** to have my information disclosed._____ _____
(Signature of Patient) **Date**

Information to Release

Treatment Dates: _____
____ Discharge Summary
____Admission Report
____History & Physical
___Psychological Testing
___Labs/EKGs
___Other (*Please Specify)* _____
___Medication List
___Dates of Hospitalization
___Aftercare Packet

_____
Information to be released via:
❑ Pick-up ❑ Fax ❑ Mail
❑ Email_____

State / Federal Laws require specific authorization to release the following types of information: (please initial)

____HIV test results

____Psychotherapy Notes

Expiration

This authorization will automatically expire in 30 days from the date of execution unless a different end date or event is specified: _____
(Date/Event)

Notice of Rights and Conditions

1. Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California WIC 5328 and Federal Regulations, CFR, Part 42, concerning the privacy of information.
2. If I refuse to sign this authorization my refusal will not affect my ability to obtain treatment.
3. If I revoke this authorization, the revocation will not have any effect on any actions taken in reliance on this authorization prior to receiving the revocation.
4. I have a right to receive a copy of this authorization.
5. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may 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 specifically required or permitted by law.
6. **If the child is 12 years of age or older**, Title XXII (California State Law [45C.F.R. 164/502(G); Cal Civil Code 56.105] requires BOTH the child/adolescents' signature as well as the legal guardians' signature.
7. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming it is accurate and consent to the release of my Protected Health Information (PHI).

Signature

_____ _____

Signature of Patient/Personal Representative **Date**

(If signed by other than the client, state relationship and authority to do so):

_____ _____

Parent / Guardian / Power Of Attorney - Relation to Patient **Date**

_____ _____

Risk Manager Signature **Date**

_____ _____

Attending Psychiatrist Signature **Date**

The attending psychiatrist in charge of this patient hereby approves/disapproves the release of information to the party specified above. If disclosure is disapproved, give reasons below. Also note any restrictions on the authorization form.

Revocation

COMPLETE ONLY TO VOID THIS CONSENT

SIGNATURE OF PATIENT/LEGAL REP: _____

If signed by other than the patient, state relationship and authority to do so