EL CENTRO REGIONAL MEDICAL CENTER

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Please read carefully and complete the second page of this form.
All sections of this authorization must be completely filled out before El Centro Regional Medical Center (ECRMC) is permitted to disclose your protected health information.

EXPLANATION: This form authorizes the **use** and **disclosure** of my protected health information in the manner described below and is voluntary. ECRMC cannot and does not condition services on whether or not I sign this authorization except under limited circumstances such as services related to research, eligibility or enrollment determinations, or services performed solely to create information for an outside requestor (such as worker's compensation). In these circumstances, ECRMC may refuse services unless I provide an authorization for the disclosure of my information. **I am aware that once my information leaves ECRMC, ECRMC will no longer be able to protect that information, and the recipients of the information may not be legally required to protect my information.**

AUTHORIZATION TO DISCLOSE SPECIFIC PROTECTED HEALTH INFORMATION: Federal and state laws require ECRMC to obtain specific authorization from patients to release sensitive information. Sensitive information is defined as treatment or documentation related to HIV and AIDS test results; Psychiatric, Alcohol or Drug Abuse Treatment. I am aware that ECRMC will try to exclude these types of information unless I specifically identify them for release. If I know my record contains this type of information, I must identify the specific type of information found under the section labeled ***Special Categories of Information.*** If I choose not to release this information, I will notify ECRMC immediately at (760) 339-7190.

DURATION: I understand this authorization may be revoked in writing at any time to: ECRMC, 1415 Ross Avenue, El Centro, CA 92243 Attn: Privacy Officer, except to the extent that action has been taken in reliance on this authorization.

RESTRICTIONS: I understand that ECRMC may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by laws. I hereby release ECRMC from any and all legal liability that may arise from the release of this information to the party named on page 2 of this authorization.

ADDITIONAL COPY: ECRMC will provide me with a copy of this Authorization

Please initial that you have read the above statements: _____
Initials

RELEASE OF INFORMATION AUTHORIZATION

MRN: _____
Facility Use Only

Authorization: I request a copy of my records or authorize the release of information pertaining to medical history, mental or physical condition, services rendered, or treatment, as described below for:

Name of Patient: _____ Date Of Birth: ____ /____ /_____

Last 4 digits of Social Security Number: _____ Telephone: (_____) _____

Record Holder: _____

Records May Be Released To: _____

_____
Street Address *City* *State* *Zip*

Telephone: (_____) _____ Fax: (_____) _____

Date of Service: From _____ /_____ /_____ To _____ /_____ /_____

Location of Treatment: ❑ Inpatient ❑ Emergency ❑ Outpatient

Type of Information: This authorization is limited to the following medical records and type of information:

❑ Discharge Summary ❑ Progress Notes ❑ Problem List
❑ History/Physical Exam ❑ Laboratory Tests ❑ Medication List
❑ Consultation Reports ❑ X-ray reports ❑ Other (please specify): _____
❑ Operative/Procedure Reports ❑ Discharge Instructions _____
❑ Emergency Department Reports ❑ Medication Allergies ❑ Electronic Media ❑ Paper

Special Categories of Information: You must specifically authorize the disclosure of the following types of information: Check all that apply:

❑ HIV (Human Immunodeficiency Virus) test results ❑ Psychiatric records
❑ Alcohol and/or drug abuse treatment

Use of Information: The requestor may use the medical records and type of information authorized only for the following purposes:

❑ Continuing Care ❑ Second Opinion ❑ Personal ❑ Insurance Claim
❑ Other (Please specify): _____

Term: Unless otherwise revoked, this Authorization will expire on the following date, (specify exact date no longer than 12 months) _____ /_____ /_____

Printed Name: _____

Signature: _____ Date: _____ /_____ /_____

If signed by other than patient, indicate relationship: _____

Witness _____