WHITTIER HOSPITAL MEDICAL CENTER
9080 COLIMA ROAD
WHITTIER, CA 90605-1898
562.907.1718 TELEPHONE / 562.693.7113 FACSIMILE

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. **Failure to provide *all* information requested may invalidate this Authorization.**

I hereby authorize **Whittier Hospital Medical Center** to use or disclose my protected health information as follows:

PATIENT IDENTIFICATION:

Patient Name: Last	First	Middle
Social Security Number	Date of Birth	Date(s) of Treatment
CONTACT PHONE NUMBER ( ) _____ ☐ Leave message with call back number only		

RELEASE TO:

Circle One - Person / Organization / Patient

Name:

Address:

City, State, Zip: Phone Number ( )

I REQUEST COPIES OF MY MEDICAL RECORD FOR THE FOLLOWING REASON:

☐ FAX For my physician (No charge)	☐ As an employee (No charge)
☐ PICKUP As the patient (0.25 per page charge)	☐ For subpoenas ($15 Witness Fee)
☐ MAIL As the patient (0.25 per page charge plus actual postage)	☐ For attorney (Pre-bill only)

TYPE OF INFORMATION TO BE RELEASED:

☐ All health information pertaining to any medical history, mental or physical condition and treatment received **EXCEPT** confidential information of a sensitive nature, psychological or psychiatric records, substance abuse (drug/alcohol), and communicable disease including HIV/AIDS, hepatitis, or venereal diseases.

☐ **Only** the following records or types of health information indicated below:

__Face Sheet	__Consultation	__EKG Reports	__X-ray Reports
__Entire Medical Record	__Discharge Summary	__ER Reports	__Other-Specify
__Pertinent Information	__History & Physical	__Lab Reports	_____
	__Operative Report	__Path Reports	

NOTICE OF RIGHTS AND OTHER INFORMATION:

- I may refuse to sign this Authorization. If you do refuse to sign, we will not be able to release your medical records to you or the requestor.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered or mailed to the:

  Health Information Management Department
  Whittier Hospital Medical Center
  9080 Colima Road
  Whittier, CA 90605
- My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.
- Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might 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 required or permitted by law. I hereby release Whittier Hospital Medical Center and its agents and employees from all liability that may arise from the release of protected health information and any re-disclosure.
- I may inspect or obtain a copy of the protected health information that I am being asked to release.
- Request for release of information takes 5-7 business days to process. You may call 562.907.1718 for the status of your request.

EXPIRATION AND SIGNATURE:

Unless I revoke this authorization, it will expire six (6) months from date signed or as specified _____.	☐ I would like a copy of this authorization. Initial_____	
Signature (Patient, Representative, Spouse):	Date:	Time:
Printed Name (Patient, Representative, Spouse):	Legal Relationship to Patient:	

REVOCATION OF REQUEST

☐ I would like to revoke this Authorization for Use or Disclosure of Protected Health Information request.		
Signature (Patient, Representative, Spouse):	Date:	Time:
Printed Name (Patient, Representative, Spouse):	Legal Relationship to Patient:	
WHMC Representative Signature:	Date:	Time:

OFFICE USE ONLY:

Identity of requestor validated either with government issued picture ID or comparison of signatures documented in records.	Date:	Time:
Records Received By:	Date:	Time:
Records Mailed Out To:	Date:	Time:
WHMC Representative Signature:	Date:	Time: