Barlow Respiratory
HOSPITAL
2000 Stadium Way
Los Angeles, CA 90026-2696
Main Phone: 213.250.4200
HIM Fax: 213.202.6490

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes Barlow Respiratory Hospital to disclose and/or use health information about you. Failure to provide ***all*** information requested may invalidate this Authorization.

Name of patient: _____

Birth Date: _____ **Social Security #**_____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize **BARLOW RESPIRATORY HOSPITAL** to release to:

Name: _____ **Phone #:** _____
Fax #: _____

Address:_____
(Street)
_____
(City, State, Zip Code)

the following information:

o All medical records

o History & Physical o Discharge Summary

o Consultation reports o Laboratory results

o X-ray reports o EKG results o PFT results

o ABG results o Procedure reports

o Other, please specify_____

PURPOSE

Purpose of requested use or disclosure: o patient request; ***OR*** o other: (explain)_____
_____

EXPIRATION

This Authorization expires (*insert date MM/DD/YYYY*): _____

MY RIGHTS

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I understand that I have the right to modify or revoke this Authorization in writing at any time subject to the exceptions stated below. To modify or revoke this Authorization, I understand that I must make my request in writing and clearly state that I am modifying or revoking this specific Authorization. In addition, I must sign my request and then mail or deliver my request to:

Barlow Respiratory Hospital
2000 Stadium Way
Los Angeles, CA 90026-2696
Attn: Director of Health Information Management

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of 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 (HIPAA).

SIGNATURE

I hereby authorize the Use or Disclosure of health information as described in this Authorization.

Signature: _____

Print Name: _____

Address: _____

(Street)

_____

(*City, State, Zip Code)*

Phone#: _____

Date: _____

If signed by someone other than the patient, state your legal relationship to the patient: _____

Witness:

Signature: _____
Print Name: _____
Date: _____

Acknowledgement:

I acknowledge receiving a signed copy of this Authorization.

Signature: _____
Print Name: _____
Date: _____

PLEASE NOTE THERE ARE FEES ASSOCIATED WITH THE DISCLOSURE OF HEALTH INFORMATION TO PATIENTS AND PATIENT REPRESENTATIVES.