MR#	ACCT#

FOUNTAIN VALLEY REGIONAL HOSPITAL

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: Last First Middle

Home Address: ____

Home Telephone:

Date of Birth:

Specify Information type to be Disclosed: Date(s)______________________________

☐ History & Physical	☐ Lab Results	☐ Consult	☐ X-Ray results
☐ Operative Reports	☐ ER Records	☐ Neurology	☐ Discharge Summary
☐ Cardiology	☐ Other ____________________		

By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ Mental Illness ______________________________
- ☐ Developmental Disability______________________________
- ☐ Psychotherapy Notes______________________________
- ☐ HIV/AIDS Testing, Diagnosis, or Treatment (regardless of result)__________________
- ☐ HIV Test Result ______________________________
- ☐ Communicable Disease______________________________
- ☐ Substance Abuse, Prevention or Treatment ______________________________
- ☐ Sexual Assault ______________________________
- ☐ Child Abuse or Neglect ______________________________
- ☐ Genetic Testing ______________________________
- ☐ Domestic Abuse ______________________________
- ☐ Elder Abuse ______________________________
- ☐ Other ______________________________

RECIPIENT: Name of person or class of persons to whom FOUNTAIN VALLEY REGIONAL HOSPITAL may disclose my health information: Person or persons who would be receiving this information:

ADDRESS: Address of the recipient or where my health information should be delivered:

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TERM: This Authorization will remain in effect:

□ From the date of this Authorization until the ______ day of ____________, _______.
□ Until FOUNTAIN VALLEY REGIONAL HOSPITAL fulfills this request.
□ Until the following event occurs ____
□ Other ____

PURPOSE: I authorize FOUNTAIN VALLEY REGIONAL HOSPITAL to use or disclose my health information (including the highly confidential I selected above, if any) during the term of this Authorization for the following specific purpose(s): **Note:** “at the request of the Patient” is sufficient if the Patient is initiating this Authorization:
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I understand that once FOUNTAIN VALLEY REGIONAL HOSPITAL discloses my health information to the recipient, FOUNTAIN VALLEY REGIONAL HOSPITAL cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable law governing the use and disclosure of my health information.

I understand that FOUNTAIN VALLEY REGIONAL HOSPITAL may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may at any time make a written request to FOUNTAIN VALLEY REGIONAL HOSPITAL to inspect and/or obtain a copy of my health information, and that FOUNTAIN VALLEY REGIONAL HOSPITAL will either, within five days for a request to inspect and fifteen days for a request to copy, grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at FOUNTAIN VALLEY REGIONAL HOSPITAL; except, however, if my treatment at FOUNTAIN VALLEY REGIONAL HOSPITAL is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case FOUNTAIN VALLEY REGIONAL HOSPITAL may refuse to treat me if I do not sign this Authorization.

I understand that, at any time during which this Authorization is in effect, I may make a written request to receive a copy of this Authorization. Such written request shall be made to FOUNTAIN VALLEY REGIONAL HOSPITAL’s Privacy Office at the address listed below.

	MR#	ACCT#

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to FOUNTAIN VALLEY REGIONAL HOSPITAL's Privacy Office at the address listed below. The revocation will be effective immediately upon FOUNTAIN VALLEY REGIONAL HOSPITAL's receipt of my written notice, except that the revocation will not have any effect on any action taken by FOUNTAIN VALLEY REGIONAL HOSPITAL in reliance on this Authorization before it received my written notice of revocation.

I may contact FOUNTAIN VALLEY REGIONAL HOSPITAL at (714) 966-8021 or by email at FVR-Privacy.Security@tenethealth.com

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize FOUNTAIN VALLEY REGIONAL HOSPITAL to use or disclose my health information in the manner described above.

_______________________________________ ______________

Signature of Patient **Date**

If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

____________________ ____________________ ______________

Signature of Personal Representative **Description of Authority** **Date**

Please complete <u>all fields</u> and return by
FAX: (714) 966-3352
Mail: FOUNTAIN VALLEY REGIONAL HOSPITAL
Release of Information
11170 Warner Ave, Ste 102
Fountain Valley, CA 92708
E-mail: FVR-Privacy.Security@tenethealth.com

Contact Release of Information directly at (714) 966-8027 if any questions or status of your request

* **For Internal Use Only:** The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records.

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Signature of employee verifying identity