AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Failure to provide *all* information requested may invalidate this Authorization.

EXPLANATION

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 et seq.

AUTHORIZATION

I hereby authorize: **PACIFIC ALLIANCE MEDICAL CENTER**

To furnish to (name of requestor): _____

Address: _____

City / State / Zip: _____

Phone Number: _____

Pertaining to medical history, mental or physical condition, service rendered, or treatment of:

Patient Name: _____ _____ _____
Last First M.I.

Maiden or Alternate Last name Used: _____

Date of Birth: _____ Social Security: _____

The authorization is limited to the following medical records and type of information:

_____

USES

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

_____

DURATION

The authorization shall become effective immediately and shall remain in effect until (date): _____

RESTRICTIONS

I understand that the requestor may not further use or disclose the medical information unless another authorizatrion is obtained from me or unless such use or disclosure is specifically required or permitted by law.

PAMC PACIFIC ALLIANCE MEDICAL CENTER
531 West College • Los Angeles, California
213.624.8411

Pacific Alliance Medical Center

DOB:

ADDITIONAL COPIES OF THIS AUTHORIZATION: **YES ❑** **NO ❑** **Initial _____**

I further understand that I have the right to receive a copy of this authorization upon my reuqest. Copy requested and received:

YOUR RIGHTS

I may refuse to sign this Authorization.

I may revoke this Auhtorization at any time, however I cannot revoke when others have depended upon this Authorization.

SIGNATURE

Date: _____ Time: _____ AM/PM

Signature: _____
(Patient/representative/spouse*/financial responsible party)

If signed by other than patient, indicate relationship: _____

Witness: _____

ID verified **YES ❑** **NO ❑** **Initial _____**

(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.)