

# San Antonio Community Hospital

999 San Bernardino Road, Upland, CA 91786

## Authorization to Use and Disclose Health Information

NOTE: (Processing of this request takes 5-10 working days)

Req. # \_\_\_\_\_

**Individual's Name:** \_\_\_\_\_  
Last First Middle

**Home Address:** \_\_\_\_\_  
\_\_\_\_\_  
(City) (State) (Zip Code)

**Home Telephone:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_

**My Health Information:** The health information that is subject to this Authorization includes:

**Dates of Services:** \_\_\_\_\_

Outpatient Services     Emergency Room     Inpatient

**User or Discloser:** Name or function of person or class of persons hereby authorized to use or disclose my health information: **San Antonio Community Hospital Medical Records Staff.**

**Recipient:** (Name or function of person or class of persons to whom *San Antonio Community Hospital* may disclose my health information)

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

(City) (State) (Zip Code)

**Term:** This Authorization will remain in effect:

From the date of this Authorization until: \_\_\_\_\_

(Date)



By my signature, I hereby authorize ***San Antonio Community Hospital*** to use/disclose to the Recipient my health information for the following specific purpose(s):

- |  |                                       |  |
|--|---------------------------------------|--|
| <input type="checkbox"/> Insurance   | <input type="checkbox"/> Disability   | <input type="checkbox"/> <b>Pickup records</b> |
| <input type="checkbox"/> Personal Use  | <input type="checkbox"/> Attorney     | <input type="checkbox"/> <b>Mail Records</b>   |
| <input type="checkbox"/> Continuing Care<br>(to a physician/healthcare facility) | <input type="checkbox"/> Other: _____ |  |

I understand that my health information may contain the following types of sensitive information:

- Documentation or analysis of any communications between me and my psychiatrist, psychologist, social worker, psychiatric nurse, mental health specialist, sexual assault counselor, domestic violence counselor or other allied mental health or human services professional.
- Venereal disease(s).
- Treatment for substance abuse.
- AIDS, ARC or HIV (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative).

**RESTRICTIONS:** California law prohibits ***San Antonio Community Hospital*** from making further disclosure of my health information unless ***San Antonio Community Hospital*** obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

I understand that once ***San Antonio Community Hospital*** discloses my health information to the Recipient in accordance with the terms and conditions of this Authorization, ***San Antonio Community Hospital*** cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may, at any time, make a written request to ***San Antonio Community Hospital*** to inspect and/or obtain a copy of my health information, and that ***San Antonio Community Hospital*** will within thirty (30) days of receiving such written request, either 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 *San Antonio Community 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 have a right to receive a copy of this Authorization.

**Copy of signed Authorization to individual**

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 *San Antonio Community Hospital's* treatment of me.

I understand that this Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to *San Antonio Community Hospital's* Health Information Management (Medical Records Department) at the address listed below. The revocation will be effective immediately upon *San Antonio Community Hospital* receipt of my written notice, except that the revocation will not have any effect on any action taken by *San Antonio Community Hospital* in reliance on this Authorization before it received my written notice of revocation. The address of *San Antonio Community Hospital* is 999 San Bernardino Road, Upland, CA 91786 and I may contact the Medical Records Department by telephone at (909) 920-4750.

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. I hereby, knowingly and voluntarily, authorize upon *San Antonio Community Hospital* to use or disclose my health information in the manner described above:

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

If individual is a minor or is otherwise unable to sign this Authorization, please complete the information below:

\_\_\_\_\_  
Signature of authorized Legal Guardian, Health Care Agent or Other authorized Personal Representative

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date