



HOSPITAL OF SOUTH BAY- TRI-CITY CAMPUS

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name: _____
Last First Middle

Home Address: _____

Home Telephone: _____ Date of Birth: _____

SPECIFY INFORMATION TO BE DISCLOSED:

- ___ Discharge Summary ___ History & Physical ___ Progress Notes ___ Orders
- ___ Consult Reports ___ Lab Results ___ X-Ray Results ___ Medication Rec.
- ___ Nursing Notes ___ Treatment Plan ___ Entire Records

Other: _____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

- Information about mental health or mental retardation services
- Psychotherapy Notes created by a mental health professional
- Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- Information about sexually transmitted diseases
- Information about alcohol or drug abuse treatment program services
- Information about sexual assault
- Information about child abuse and neglect

RECIPIENT: Name of person or class of persons to whom Rancho Specialty Hospital may disclose my health information: _____

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

TERM: This Authorization will remain in effect:

- From the date of this Authorization until the _____ day of _____, 200__.
- Until Vista Hospital of South Bay- Tri-City Campus fulfills this request.
- Until the following event occurs: _____.
- Other: _____.



HOSPITAL OF SOUTH BAY- TRI-CITY CAMPUS

I understand that once Vista Hospital of South Bay-Tri-City Campus discloses my health information to the recipient, Vista Hospital of South Bay- Tri-City Campus cannot guarantee that the 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 California law governing the use and disclosure of my health information.

I understand that Vista Hospital of South Bay- Tri-City Campus 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 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 Vista Hospital of South-Bay Tri-City Campus; except, however, if my treatment at Vista Hospital is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Vista Hospital may refuse to treat me if I do not sign this Authorization.

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 the hospital's Privacy Office at the address listed below. The revocation will be effective immediately upon Vista Hospital's receipt of my written notice, except that the revocation will not have any effect on any action taken by Vista Hospital of South-Bay Tri-City Campus in reliance on this Authorization before it received my written notice of revocation.

I may contact the Privacy Officer by mail:

10841 White Oak Ave, Rancho Cucamonga CA 91730

by confidential voice mail (909) 527-8938, or by email Privacyofficer@vistahealthcare.net

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, I hereby, knowingly and voluntarily authorize Vista Hospital of South Bay TriCity Campus to use or disclose my health information in the manner described above.

Signature of Patient

Date

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

Signature of Authorized
Legal Representative

Relationship to
the Patient

Date

REDISCLASURE RESTRICTION

The information contained in these medical records has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 C.F.R. part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical information is NOT sufficient. These records are for one purpose only and are not to be duplicated. They are to be destroyed when their purpose has been completed.