Ridley-Tree Cancer Center

sansum CLINIC

Patient Name:_____

MRN:_____
(Do not affix label, print clearly)

AUTHORIZATION FOR USE / DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this HIPAA-compliant form authorizes the use and/or disclosure of Protected Health Information (PHI) by the person(s) or entity identified herein and in keeping with State law and Federal regulations governing health information access, patient privacy and record confidentiality. To assist us in the timely processing and delivery of your request, please fill out this form accurately and completely.

Part 1 - AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PHI

[*NOTE:* Copies of last 2 years of your records are sent cost-free to outside providers when specified.]

I, the Patient, _____, authorize the use and/or disclosure of my medical records or PHI as stored and maintained at Sansum Clinic.

Preferred format of records to be used and/or disclosed: (C*heck one*) Paper ___ CD___

Patient's full name: _____ **Phone:** _____

Patient's current address: _____

Patient identifiers (DOB / Last 4 of SSN / MRN / CA DL# / *etc.*; *minimum of 2 identifiers required*):

(1) _____ (2) _____

***FROM*: (Name and location of provider/department where PHI is maintained if known)**

_____

***TO*: (Person to whom access is being granted or recipient of copies to be sent**, including address and phone number when available)

_____

This Authorization applies only to the following records (*check **one or more** of the following*):

☐ **Last 2 years** of PHI pertinent to my medical history, mental or physical condition, as well as treatment received during same period. [*OPTIONAL*] Except (*describe*): _____

_____

☐ Results of test(s) to detect the probability of Human Immunodeficiency Virus (HIV), which is the probable causative agent of Acquired Immune Deficiency Syndrome (AIDS).

☐ Psychiatric /mental health records ☐ Substance abuse records

☐ **Only** the following PHI, including any associated dates or events (*please describe*):

_____

Part 2 - IF ANOTHER REQUESTOR (NOT THE PATIENT) OR SANSUM CLINIC SEEKS AUTHORIZED DISCLOSURE

My medical records or PHI will be used for the following purpose(s):

_____ Continuity of care

_____ Changing provider

_____ Insurance eligibility/benefits

_____ Legal or regulatory process/action; law enforcement

_____ Personal (at request of patient or patient representative)

_____ Other (*specify*):_____

I, the Patient, may inspect or obtain a copy of the medical records or PHI that I am being asked to release or disclose. I understand that treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this Authorization.

Part 3 - EXPIRATION DATE

This Authorization expires exactly one (1) year from the effective date or on date indicated here (MM/DD/YYYY), whichever comes first. **Expiration Date: ___/___/_____**

Part 4 - RESTRICTIONS TO REQUESTOR

California law prohibits the Requestor from making further disclosure of PHI without express patient authorization unless such disclosure is specifically required or permitted by law.

***NOTE TO PATIENT*:** *If you have authorized the use, release, and/or disclosure of your health information to someone who is not legally required to keep it confidential, it may be redisclosed and therefore may no longer be protected. California law prohibits recipients of your PHI from further redisclosure without your written authorization or as specifically required or permitted by law.*

Part 5 - YOUR RIGHTS AS A PATIENT

(A) I may refuse to sign this Authorization. **(B)** I may revoke this Authorization at any time. My revocation must be in writing and must be signed and dated by me or by my representative, and delivered to: **Sansum Clinic, HIS / Release of Information (ROI), 89 South Patterson Avenue, Santa Barbara, CA 93111** *ROI Telephone:* (805) 692-6435 - *ROI Fax:* (805) 692-4699

(C) My revocation is effective upon receipt but is void to the extent that the Requestor or others may have already acted in reliance upon this Authorization. **(D)** I have the right to receive a copy of this Authorization.

Part 6 - PATIENT SIGNATURE / AUTHENTICATION

With my signature on this Authorization, I confirm that it reflects accurately my wishes and affirm that I understand it fully and completely.

Today's Date (**Effective Date**): _____ Time: _____ AM / PM [c*ircle which*]

Signature: _____ Patient / Patient Representative [c*ircle who*]

Patient Representative Identifiers (*minimum of two required; see Page 1 of this form.*):

(1) _____ (2) _____

If signature above belongs to patient representative, relationship to the patient: _____

Name / initials of receiving ROI or Clinic staff): _____ Date: _____

NOTE TO STAFF*:** ***(1) Patient or patient representative is provided a copy of this Authorization when it has been requested by a covered entity (*e.g.* Cottage Hospital) for its own use and/or disclosures. (***2***) The Requestor (*e.g.* Sansum Clinic/Cottage Hospital/other third party requestor such as an outside physician) may use and complete this form except Part 6, which is completed by the patient or patient representative. (***3***This Authorization form does not apply if the Requestor is seeking to use PHI (a) to conduct research-related treatment; (b) to obtain information in connection with individual eligibility or enrollment in a health plan of which the individual is not already a member; (c) to enable the Requestor to determine its obligation to pay a claim; or (d) to create health information to provide to a third party. Under no circumstances is the patient required to authorize the disclosure of psychotherapy notes by using this or any other form. (***4***) A spouse or financially responsible party may only authorize release of medical information or PHI for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a nonprofit hospital plan, a health care service plan, or an employee benefit plan.