Huntington-Hill
Breast & Imaging Centers

Jim & Eleanor Randall
Breast Center
A Huntington Hospital & Hill Imaging Partnership

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please send all medical files and records to:
The Hill Medical Corp., ATTN: Medical Records
223 N. First Avenue, Suite 101Arcadia, CA 91006
(626) 203-4924 / Fax (626) 446-8952
MedicalRecords@cmbsllc.net

☐ **Huntington-Hill Imaging Center** Cordova
☐ **Huntington-Hill Imaging Center** Fair Oaks
☐ **Huntington-Hill Imaging Center** Glendora
☐ **Huntington-Hill Imaging Center** West Covina
☐ **Huntington-Hill Breast Center** Arcadia
☐ **Jim & Eleanor Randall Breast Center**

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record.
(Name of Patient)

II. The information is to be provided to (check an option below and provide the contact information on the lines provided):
☐ Patient ☐ Patient's Agent or Family ☐ Organization/Facility ☐ Huntington-Hill Imaging Centers (provide facility to contact for prior images)
Name _____
Address _____
Fax or Email (for radiology reports only) _____

III. The purpose or need for this disclosure is: ☐ Medical Care ☐ Personal Use ☐ School ☐ Insurance ☐ Attorney ☐ Disability ☐ Research
☐ Other *(specify)* _____

IV. The information to be disclosed from my health record: *(check appropriate box/es)*
☐ Only information related to *(specify)* _____
_____
☐ Only the period of events from _____ to _____
☐ Other *(specify) (CHS, Billing, Sensitive Information, etc.)* _____
☐ Entire Record

V. I understand that I may revoke this authorization in writing submitted at any time to the THMC Privacy Officer, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

_____
(Specify new date)

I understand that *The Hill Medical Corporation* will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) Research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGN HERE → **Signature of Patient or Personal Representative *(State relationship to patient)***	Date
Signature of Witness *(If signature of patient is a thumbprint or mark)*	Date

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

PATIENT IDENTIFICATION *(Copy ID or Document ID Verification Below)*

☐ Visual Confirmation ☐ Type _____ ☐ # _____

Name (Last, First, MI)			Record Number
Address / City / State / Zip - or - Alternative Identifier *(in RIS)*			
Contact Phone			Date of Birth
Collected By	Packaged By	QA By	Released By

FORMAT RELEASED: ☐ CD ☐ Film ☐ Report ☐ Courier

Instructions for Completing This Form

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink.
2. Section I, print your name or the name of patient whose information is to be released.
3. Section II, check a box corresponding to the facility releasing the information. Also, provide the name of the person, facility, and address that will receive the information.
4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc.
5. Section IV, check the appropriate box as applicable.
    a. **Only information related to** – specify diagnosis, injury, operations, special therapies, etc.
    b. **Only the period of events from** – specify date range, e.g., Jan. 1, 2014, to Feb. 1, 2014.
    c. **Other *(specify)*** – e.g., Physician, Billing, Employee Health.
    d. **Entire Record** – complete record, not including sensitive information covered in e. below.
    e. **Sensitive Information – In order to release sensitive information regarding alcohol/drug abuse treatment/referral, hiv/aids-related treatment, sexually transmitted diseases, mental health (other than psychotherapy notes), you must check "Other" and specify which sensitive information you are authorizing.**
6. Section V, if a different expiration date is desired, specify a new date.
7. Section V, Please sign (or mark) and date.
8. A copy of the completed authorization for use and disclosure form will be given to you.