



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 101 Arcadia, CA 91006
 (626) 203-4924 / Fax (626) 446-8952
 MedicalRecords@cmbssl.com

- Huntington-Hill Imaging Center Cordova
- Huntington-Hill Imaging Center West Covina
- Huntington-Hill Imaging Center Fair Oaks
- Huntington-Hill Breast Center Arcadia
- Huntington-Hill Imaging Center Glendora

COMPLETE ALL SECTIONS, DATE, AND SIGN

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 If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.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].

<div style="background-color: yellow; padding: 2px; display: inline-block;">SIGN HERE</div> <div style="display: inline-block; vertical-align: middle;"> <p>Signature of Patient or Personal Representative (State relationship to patient)</p> <p>_____</p> <p>Signature of Witness (If signature of patient is a thumbprint or mark)</p> <p>_____</p> </div>	<p>Date</p> <p>_____</p> <p>Date</p> <p>_____</p>
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This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

<p>PATIENT IDENTIFICATION (Copy ID or Document ID Verification Below)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Visual Confirmation <input type="checkbox"/> Type _____ <input type="checkbox"/> # _____</p>	<p>Name (Last, First, MI)</p> <p>_____</p>	<p>Record Number</p> <p>_____</p>	
	<p>Address / City / State / Zip - or - Alternative Identifier (in RIS)</p> <p>_____</p>		
	<p>Contact Phone</p> <p>_____</p>	<p>Date of Birth</p> <p>_____</p>	
	<p>Collected By</p> <p>_____</p>	<p>Packaged By</p> <p>_____</p>	<p>QA By</p> <p>_____</p>

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.