Antelope Valley Medical Center
A facility of Antelope Valley Healthcare District
1600 West Avenue J, Lancaster, CA 93534
www.avmc.org

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization.

PATIENT INFORMATION				
Patient's Name:	Last	First	Middle Initial	Birth Date

I hereby authorize **Antelope Valley Medical Center** to release protected health information to:

USE AND DISCLOSURE OF HEALTH INFORMATION				
Authorized to Receive information:		(Full Name of person or organization)		
Address	(complete address)	City	State	Zip Code

Release:

- ☐ Abstract Only (**First Abstract Free of Charge** – All pertinent information including Face sheet, Emergency Room Records, Physician dictated reports and diagnostic reports)
- ☐ Limit to Specific Reports _____
- ☐ All health information pertaining to any medical history, mental or physical condition and treatment received.

Limits: I specifically authorize release of the following information (check as appropriate):

- ☐ General Medical/Surgical ☐ Mental Health Records ☐ HIV Test Results
- ☐ Other - Specify:_____

Dates of Service: ☐ All ☐ Specific dates:_____

Method of disclosure: ☐ mail ☐ pick up ☐ review/inspect ☐ fax to #_____
☐ Email_____
☐ Compact Disc *(only applies to electronic records)* ☐ other_____
Do you wish to be notified by phone if records are being faxed? ☐ Yes ☐ No
If yes, indicate phone #_____

For Appointment? ☐ No ☐ Yes Date needed by:_____

Purpose: The protected health information is being used or disclosed for the following purpose(s):

☐ Personal Use ☐ Continued Care ☐ Other _____

Expiration: This authorization expires one year from date signed unless otherwise specified: _____
Date/Event

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

NOTICE OF RIGHTS AND OTHER INFORMATION

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: Antelope Valley Medical Center – Medical Records Department 1600 West Avenue J, Lancaster, CA 93534.

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefit.

SIGN BELOW:

Date	Signature (patient/representative/spouse/financially responsible party)
If signed by someone other than the patient, state your legal relationship to the patient:	
Print Name	Phone #
Address	

FOR MEDICAL RECORDS DEPARTMENT USE ONLY

Copy of this form to requestor? ☐ Yes ☐ No ☐ NA
Charges/Deposits discussed? ☐ Yes ☐ No ☐ NA

Verification and Witness: ID Verified
☐ Picture ID ☐ Wristband ☐ Signature Comparison
☐ Last 4 digits of social security number_____ ☐ Other: _____

Witness Signature	Print name and title	Date