Instructions to Completing the Authorization for Protected Health Information (PHI)

These instructions were designed to help answer any questions that may arise when completing the *Authorization Form for the Release of Protected Health Information*.

Section A-

Patient's Name	The name of the person who received the medical service(s).
Birth Date	The patient's date of birth.
Patient's Phone	A phone number where the patient may be reached.
Social Security Number	Last four digits of the patient's social security number. - ***This field is optional.***
Provider's Name	Name of the facility or hospital where the patient service was performed.
Provider's Address	Complete Mailing Address of the facility or hospital.
Recipient's Name	Name of the person being authorized by the patient to receive the requested protected health information.
Recipient's Address	Complete mailing address for the designated "Recipient." Please be sure to include your zip code.
Recipient's Phone	A phone number where the recipient of the medical information can be reached.
Request Delivery	Specify how the recipient is to receive the requested information.
Email	Complete only if eDelivery is requested.
Expiration Date or Event	Authorization will expire in 90 days unless otherwise noted on this form.
Purpose of Disclosure	Explain why the requested protected health information is being requested.
Psychotherapy Notes	Mark the "Yes" box if the information being requested is Psychotherapy-related. Mark the "No" box if the information is not related to Psychotherapy.
Description of Information to be Used or Disclosed	***Description***- Mark the box that best describes the type of health information requested for use or disclosure. ***Please note:*** ***ABSTRACT*** *only includes your face sheet, discharge summary, history and physical, consults, path, radiology and lab reports and any operative report.* ***Date(s)***- Provide the date of service related to when the medical treatment was rendered. If the requested information being requested pertains to an inpatient hospital stay, provide the discharge date. ***Consent to Release***- Initial this box if you acknowledge and consent to the release of protected health information that may contain alcohol/drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.

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Section B-

This section needs to be completed only if the request is for marketing purposes and the patient received compensation in exchange for this information. Select "Yes" or "NO". If "Yes," provide a brief explanation.

Section C-

Signature of Patient/Guardian or Personal Representative	The patient's signature is always required, unless the patient is a minor or a legal representative has been appointed.
Date Signed	Provide the date that this authorization form was signed.
Printed Name of Patient/Guardian or Personal Representative	Print the name of the individual who signed this authorization form.
Relationship of Personal Representative to Patient	If someone other than the patient signs the authorization form, a description of the representative's authority to act on behalf of the patient must be provided (i.e. Medical Power of Attorney, Executor of Estate, or Legal Guardian). Also, please include a copy of all supporting documentation (i.e. a copy of the medical power of attorney, court order for Executor of Estate, or court order for guardianship.

Please return Authorization to:
Los Robles Hospital and Medical Center
ATTN: HIM/ MEDICAL RECORDS
215 WEST JANSS RD.
THOUSAND OAKS, CA 91360
Phone: 805-370-4895 | Fax: 805-370-4726

Authorization for the Release of Protected Health Information

Section A: This section must be completed for all Authorizations			
Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4-digit SSN (optional)**
Provider's Name: **Los Robles Hospital and Medical Center**	**Recipient's Name:**		
Provider's Address: **215 WEST JANSS RD.** **THOUSAND OAKS, CA 91360**	**Address 1:**		
	Address 2:	**Recipient's Phone:**	
	City:	**State:**	**Zip:**

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.,* USB drive, CD/DVD, eDelivery)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.*, paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.*, virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	*Date(s):*	*Description:*	*Date(s):*	*Description:*	*Date(s):*
☐ ABSTRACT only ☐ **My entire medical record** (all PHI – Personal Health Information) ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake		☐ Clinical test ☐ Medication sheets ☐ Operative information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm strips ☐ Nursing information ☐ Transfer forms ☐ ER information		☐ Labor/delivery summary ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-04: ☐ Other: ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information.

_____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

May the recipient of the PHI further exchange the information for financial remuneration?

☐ Yes ☐ No

Section C: Signatures	
I have read the above and authorize the disclosure of the protected health information as stated.	
Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

ROI

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