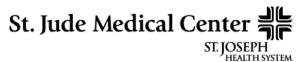


AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization.

EXPLANATION					
This authorization is being re	equested of you to cor	mply with the terms of the Confidentiality of			
the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance					
Portability and Accountability Act (HIPAA) of 2003.					
Name of Patient:	, <u> </u>				
Date of Birth:	SSN:				
USE AND DISCLOSURE OF HEALTH INFORMATION					
I hereby Authorize St. Jude Medical Center to release my Medical Record to:					
Name/Facility:		Attention:			
Address:		Phone:			
City: Stat	e: Zip:	FAX:			
Mail Copy To: (Address		Hold for Pick Up			
<u> </u>	•	you would like a thumb drive.			
INFORMATION TO BE RELEASED (Only check one box in this section) Pertinent Information: (This is what most patients and physicians need)					
		Consultations, Operative Reports, Labs,			
	G, EKG, Pathology Re	· · · · · · · · · · · · · · · · · · ·			
		dical history, mental or physical condition			
OR Only the following records or types of health information:					
only the following records of types of fleditif information.					
Specify the Date or Time Period For the Information Above:					
Specify the Date of Time renout of the information Above.					
ALITHODIZATION TO DELL	EVCE CTVLITUDII A	PROTECTED INFORMATION			
I specifically authorize release of the following information (check and initial as appropriate): Mental health treatment information Initial if requesting:					
	l IIIIOITTIaliott	Initial if requesting:			
HIV test results		Initial if requesting:			
Alcohol/drug treatment information Initial if requesting:					
A separate authorization is required to authorize the disclosure or use of psychotherapy					
notes.					
PURPOSE	1' 1				
Purpose of requested use of					
Patient Request	Continuing Care	L Legal			
Insurance	Other				

101 E. Valencia Mesa Drive, Fullerton, CA 92835 Phone (714) 992-3940 Fax (714) 992-3098



AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

EXPIRATION				
This Authorization ex	oires [insert da	ate]:		
If no Date is given; this authorization will expire 6 months from the signature date.				
MY RIGHTS				
,	information o	ion. If I refuse to sign this Authorizatio cannot be released. My refusal will no gibility for benefits.		
I may inspect or obtainuse or disclosure of.	n a copy of th	ne health information that I am being a	sked to allow the	
I may revoke this auth following address:	St. Jude Me		d submit it to the	
		mation Services-Correspondence ncia Mesa Drive A 92835		
My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.				
I have a right to receive Copy requested and received the copy requested the copy reques		his Authorization.		
Yes No		itial:	Date:	
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).				
SIGNATURE			Data	
Patient Signature:	Cianaturo		Date:	
Legal Representative	•		Date:	
(Patient representative/spouse/financial responsible party) If signed by someone other than the patient, state your legal relationship to the patient and				
why you have the aut		, , , ,	To the patient and	
Witness Signature:			Date:	

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Revision: 20110524