Pomona Valley Hospital Medical Center AUTHORIZATION TO USE/DISCLOSE (RELEASE) HEALTH INFORMATION

This authorization is for Use and Disclosure of Protected Health Information for reasons other than treatment, payment or healthcare operations.

PATIENT IDENTIFYING INFORMATION

Patient's Name				
Date of Birth			y Number	
I authorize Pomona Valley Hospital Medical Cenhealth information as described below.				
The following individual or organization is authoriz are being released for Personal Use, there will be				
RE	LEASE RECORDS	ТО		
Name /Organization	Phone Number			
Address	City		_ State	_ Zip Code
Purpose(s) of Disclosure	· ·			•
(Including any limitations on use or disclosure) _				
INFORM	MATION TO BE RE	LEASED		
Medical Records	Lab/Pathology	Slides		_ Neuro/Sleep Studies
	Emergency Re			_ Cardiology
	Other: Describe			•
Specify Dates of Treatment				
I understand that the information in my health record AIDS or HIV. It also may include information about b	rd may include informa ehavioral or mental hea	tion relating to alth services a	sexually trans nd treatment fo	smitted disease (STDs), r alcohol and drug abuse.
Please Initial				
	YOUR RIGHTS			
I understand that I may refuse to sign this authorizator payment or my eligibility for benefits.	ation and that my refus	al to sign will	not affect my a	bility to obtain treatment
I may revoke this authorization at any time. My rev Pomona Valley Hospital Medical Center ATTN: Me CA 91767	rocation must be in wri edical Records, Relea	ting, signed by se of Informa	y me or on my tion, 1798 N. C	behalf and delivered to Sarey Avenue, Pomona,
My revocation will be effective upon receipt, but will rupon this Authorization. For further information, plea	not be effective to the exase see Hospital's Notice	ktent that the F ce of Privacy F	lospital or other Practices.	s have acted in reliance
It is possible that the information disclosed under longer protected by federal or state privacy laws.	this Authorization coul	d be subject t	o redisclosure	by the recipient and no
I have a right to receive a copy of this Authorization.	on. I acknowledge tha	t this Authoriz	zation was fille	d out completely when
I understand that there may be circumstances that	at would allow the Hos	pital to receiv	e a fee in excl	nange for disclosing the
information requested on this Authorization.	SIGNATURE			
Signature of Patient/Legal Representative			Г)ato
Relationship to Patient/Authority to Act for Patient _				
	Identification Verified			
Authorization Expires (Date or Event/Condition) ORIGINAL (WHITE) - Medical	Records	CANARY -	- Patient Copy	34429 (Rev. 2/03)