Western Medical Center Anaheim
1025 South Anaheim Boulevard
Anaheim, CA 92805

# AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Medical Record # _____

Patient's Name: _____
**Last** **First** **Middle**

Home Address: _____

Home Telephone: _____ Date of Birth: _____

**SPECIFY INFORMATION TO BE DISCLOSED:** The information that may be disclosed under this Authorization includes:

☐ Discharge Summary ☐ History & Physical ☐ Consultation ☐ Radiology

☐ Operative Report ☐ Laboratory ☐ Pertinent Info (Dictated Reports, Lab,EKG)

**DATE(S) OF TREATMENT:** _____

**MY HIGHLY CONFIDENTIAL INFORMATION:**

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about mental health or mental retardation services
☐ Psychotherapy Notes created by a mental health professional
☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ Information about sexually transmitted diseases
☐ Information about alcohol or drug abuse treatment program services
☐ Information about sexual assault
☐ Information about child abuse and neglect

**RECIPIENT:** Name of person or class of persons to whom Western Medical Center Anaheim may disclose my health information: _____.

Address of the recipient or where my health information should be delivered:_____

_____

**TERM:** This Authorization will remain in effect:

☐ From the date of this Authorization until the _____ day of _____ 200_

☐ Until Western Medical Center Anaheim Center fulfills this request.

☐ Other: _____

**PURPOSE:** I authorize Western Medical Center Anaheim to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): [Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization]_____.

Western Medical Center Anaheim
1025 South Anaheim Boulevard
Anaheim, CA 92805

I understand that once Western Medical Center Anaheim discloses my health information to the recipient, Western Medical Center Anaheim cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and California law governing the use and disclosure of my health information.

I understand that Western Medical Center Anaheim may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Western Medical Center Anaheim; except, however, if my treatment at Western Medical Center Anaheim is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Western Medical Center Anaheim may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Western Medical Center Anaheim's Privacy Office at the address listed below. The revocation will be effective immediately upon Western Medical Center Anaheim's receipt of my written notice, except that the revocation will not have any effect on any action taken by Western Medical Center Anaheim in reliance on this Authorization before it received my written notice of revocation.

I may contact Western Medical Center Anaheim's Privacy Office by mail at 1025 South Anaheim Blvd., Anaheim, CA 92805, OR by telephone at (714) 533-6220 or by e-mail at WMCA-PRIVACY@TENETHEALTH.COM.

**Additional Copy:** I further understand that I have a right to receive a copy of this authorization upon my request. Copy requested and received:

☐ Yes ☐ No Initial:

**I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Western Medical Center Anaheim to use or disclose my health information in the manner described above.**

_____ _____

**Signature of Patient** **Date**

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures

_____ _____ _____

Signature of Authorized Personal Representative | Relationship to Patient* | Date

Witness: _____ _____

Signature Date

***Note: If acting as a Conservator, Beneficiary or Power of Attorney, you must furnish a copy of your appointment papers with this Authorization.**