Mission Community Hospital™
Compassionate Healthcare. Quality Healthcare.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Record Number: _____

Date of Birth: _____ SSN: _____

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.

The following individual or organization is authorized to **make** the disclosure:

MISSION COMMUNITY HOSPITAL
14850 ROSCOE BOULEVARD
PANORAMA CITY, CALIFORNIA 91402

Individual or organization authorized to **receive** information:
(send my records to:)

Sierra Infonet Services, Inc.
P.O. BOX 6200
Cypress, CA 90630-0022

Purpose of request or use of disclosure_____

_____

I authorize the use and disclosure of the above named individual's health information as described on the reverse side.

14850 Roscoe Boulevard • Panorama City, CA 91402 • (818) 787-2222
www.MCHonline.org

Type and amount of information to be used or disclosed is as follows (include specifics and dates if appropriate):

_____ Discharge Summary _____ History and Physical _____ Labs

_____ Consultation _____ Operative Report _____ Meds.

_____ X-ray reports _____ Other: _____

_____

I specifically authorize the release of the following information:
*(**INITIAL ALL THAT APPLY**)

*_____ Mental Health Treatment Information _____ HIV test result

*_____ Alcohol / Drug Treatment Information

This authorization will **expire** on _____. If I fail to specify an expiration date, this authorization will expire in six months.

I may refuse to sign this authorization.

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

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality laws (HIPAA). If I have questions about disclosures of my health information, I may contact the hospital's Privacy Officer at (818) 904-3541.

_____ _____
Signature of Patient, parent/guardian, or Power of Attorney Date

_____ _____
If not signed by patient, relationship to patient Witness Signature