AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT IDENTIFICATION SHEET:

PATIENT FIRST NAME: _____ PATIENT LAST NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER (*Optional)*: _____

CURRENT ADDRESS: _____

CITY/STATE/ZIP CODE: _____

PHONE NUMBER: (_____) _____

SEND THE REQUESTED RECORDS TO:

NAME OF RECIPIENT: _____

RECIPIENT ADDRESS: _____

CITY/STATE/ZIP CODE: _____

THE HEALTHCARE AGENCY NEEDS ADEQUATE TIME TO PROCESS RECORD REQUESTS, AND IS ALLOTED 15 DAYS TO DO SO, WHICH IS IN COMPLIANCE WITH THE CALIFORNIA HEALTH AND SAFETY CODE. PLEASE CHECK HOW YOU WOULD LIKE TO RECEIVE YOUR RECORDS:

☐ Records Mailed: A minimal fee may be required depending on the page count of requested documents.

☐ Pick up Records at Channel Islands Student Health Services within 15 business days from request.

☐ Emailed to: _____ (No fee associated with this method.)

PATIENT RIGHTS:

This authorization for use or disclosure of Protected Health Information is intended to satisfy the requirements of the Health Insurance Portability and Accountability Act (HIPPA) [42 C.F. R.164.500 et seq.] and the California Confidentiality of Medical Information Act [Civil Code Section 56 et seq.].

Please understand you have the right to revoke this authorization, in writing, at any time by sending such written notification to the Health Information Management department at One University Dr., Camarillo, CA, 93012. The revocation does not apply to information that has already been released in response to this authorization or to insurance companies that have the right to request information to contest a claim under a patient's insurance policy.

Please understand that California law prohibits the recipient of your health information from making further disclosures of it without obtaining an additional authorization from you, except in cases in which a further disclosure is permitted or required by law. The use or disclosure of the information specified in this authorization is voluntary. The VCMC Health Care Agency will not condition treatment, payment, enrollment, in a health plan or eligibility for benefits (if applicable) as a result of signing or refusing to sign this form.

You also have a right to receive a copy of this authorization upon request. _____ ***Initial receipt copy***

QUESTIONS REGARDING DISCLOSURE OF HEALTH INFORMATION:

CHANNEL ISLANDS STUDENT HEALTH SERVICES: (805) 437- 8828

FAX AUTHORIZATION BACK TO: SHS (805) 437-8829

Please review and complete the authorization carefully.
Failure to provide all the requested information may invalidate the authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Ventura County Health Care Agency at CI Student Health Services to *(check all those that apply)***:**

☐ Use the protected health information described below, and/or

☐ Disclose the protected health information described below

I hereby authorize the release of the following information *(check all that apply)***:**

☐ Entire medical record
☐ History and physical
☐ Progress notes
☐ Consultation reports
☐ Operative report
☐ Discharge summary
☐ Laboratory reports
☐ Pathology reports
☐ Radiology reports
☐ Radiology images
☐ Immunization records
☐ Emergency records
☐ Photographs, videotapes, digital images
☐ Other: please specify: _____

If present, I give permission to release ANY sensitive information *(check all that apply)***:**

☐ Substance abuse
☐ Child & domestic abuse history
☐ Genetic test results
☐ Psychiatric/mental health information
☐ Communicable and sexually transmitted diseases
☐ HIV information

DATES OF SERVICE REQUESTED FROM: _____ TO:_____

PURPOSE OF DISCLOSURE:

☐ Further medical care
☐ Personal
☐ Insurance eligibility/benefits
☐ Legal investigation/action
☐ Changing physicians
☐ Other: _____

EXPIRATION:
This authorization shall become effective immediately and shall remain in effect until _____ *(enter date)* at which this time this authorization to use or disclose this protected health information expires. If the patient fails to specify an expiration date, this authorization will expire six months from the date on which it was signed.

SIGNATURE:

_____ _____
Signature of patient or legal/personal representative **Date**

If signed by a legal/personal representative of the patient, describe the representative's authority to act for the patient *(attach supporting documentation)***:** _____

_____ _____
Signature of witness **Date**