San Antonio Regional Hospital

999 San Bernardino Road, Upland, CA 91786

Authorization to Use and Disclose Health Information

Req. # ________________

Individual's Name: ____
Last First Middle

Home Address: ____

____
(City) (State) (Zip Code)

Home Telephone: ______________________________ **Date of Birth:** _______________

Social Security #: ______________________________

My Health Information: The health information that is subject to this Authorization includes:

Dates of Services: ____

☐ Medical Records ☐ Billing Records Radiology Images on: ☐ CD or ☐ E-mail

User or Discloser: Name or function of person or class of persons hereby authorized to use or disclose my health information: **San Antonio Regional Hospital.**

Recipient: (Name or function of person or class of persons to whom ***San Antonio Regional Hospital*** may disclose my health information)

Name: ____

Address: ____

____
(City) (State) (Zip Code)

This Authorization expires on: ________________________________
(Valid for six months unless specified above) (Date)

By my signature, I hereby authorize ***San Antonio Regional Hospital*** to use/disclose to the Recipient my health information for the following specific purpose(s):

☐ Insurance ☐ Disability ☐ Continuing Care (to a physician/healthcare facility)

☐ Personal Use ☐ Attorney ☐ Other: ___________________________

Delivery Preference: ☐ Pick up Records ☐ Mail Records ☐ E-mail Address _______________

I specifically authorize release of the following information (check as appropriate):

☐ Mental health treatment in formation __________ (initial)

☐ HIV test results __________ (initial)

☐ The following substance use disorder treatment information:

____

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RESTRICTIONS: California law prohibits ***San Antonio Regional Hospital*** from making further disclosure of my health information unless ***San Antonio Regional Hospital*** obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

I understand that once ***San Antonio Regional Hospital*** discloses my health information to the Recipient in accordance with the terms and conditions of this Authorization, ***San Antonio Regional Hospital*** cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may, at any time, make a written request to ***San Antonio Regional Hospital*** to inspect and/or obtain a copy of my health information, and that ***San Antonio Regional Hospital*** will within thirty (30) days of receiving such written request, either grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.

I understand that ***San Antonio Regional Hospital*** 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 have a right to receive a copy of this Authorization.

□ Copy **of signed Authorization to individual**

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 ***San Antonio Regional Hospital's*** treatment of me.

I understand that this Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to ***San Antonio Regional Hospital's*** Health Information Management (Medical Records Department) at the address listed below. The revocation will be effective immediately upon ***San Antonio Regional Hospital*** receipt of my written notice, except that the revocation will not have any effect on any action taken by ***San Antonio Regional Hospital*** in reliance on this Authorization before it received my written notice of revocation. The address of ***San Antonio Regional Hospital*** is 999 San Bernardino Road, Upland, CA 91786 and I may contact the Medical Records Department by telephone at (909) 579-6976 ext. 26976 or 24490, Fax to (909) 920-4745 or E-mail to Release-of-information@SARH.org

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. I hereby, knowingly and voluntarily, authorize upon ***San Antonio Regional Hospital*** to use or disclose my health information in the manner described above:

Signature of Individual	Date	Signature of Witness

If individual is a minor or is otherwise unable to sign this Authorization, please complete the information below:

Signature of authorized Legal Guardian, Health Agent or Other authorized Personal Representative	Relationship Care
Witness	Date