SIERRA VISTA REGIONAL MEDICAL CENTER

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:	_____ Last First Middle
Home Address:	
Home Telephone:	
Date of Birth:	

Specify Information to be Disclosed:

_____

_____

By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ Mental Illness _____
- ☐ Developmental Disability _____
- ☐ Psychotherapy Notes _____
- ☐ HIV/AIDS Testing, Diagnosis, or Treatment (regardless of result) _____
- ☐ HIV Test Result
- ☐ Communicable Disease _____
- ☐ Substance Abuse, Prevention or Treatment _____
- ☐ Sexual Assault _____
- ☐ Child Abuse or Neglect _____
- ☐ Genetic Testing _____
- ☐ Domestic Abuse _____
- ☐ Elder Abuse _____
- ☐ Other _____

RECIPIENT: **Name of person or class of persons to whom Sierra Vista Regional Medical Center may disclose my health information:**

ADDRESS**: 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_____, 20__.
- ☐ Until Sierra Vista Regional Medical Center fulfills this request.
- ☐ Until the following event occurs _____
- ☐ Other _____

PURPOSE: I authorize Sierra Vista Regional Medical Center to use or disclose my health information (including the highly confidential 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:

_____

_____

I understand that once Sierra Vista Regional Medical Center discloses my health information to the recipient, Sierra Vista Regional Medical Center 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 law governing the use and disclosure of my health information.

I understand that Sierra Vista Regional Medical Center 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 at any time make a written request to Sierra Vista Regional Medical Center to inspect and/or obtain a copy of my health information, and that Sierra Vista Regional Medical Center will either, within five days for a request to inspect and fifteen days for a request to copy, 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 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 Sierra Vista Regional Medical Center; except, however, if my treatment at Sierra Vista Regional Medical Center is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Sierra Vista Regional Medical Center may refuse to treat me if I do not sign this Authorization.

I understand that, at any time during which this Authorization is in effect, I may make a written request to receive a copy of this Authorization. Such written request shall be made to Sierra Vista Regional Medical Center’s Privacy Office at the address listed below.

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 Sierra Vista Regional Medical Center’s Privacy Office at the address listed below. The revocation will be effective immediately upon Sierra Vista Regional Medical Center’s receipt of my written notice, except that the revocation will not have

any effect on any action taken by Sierra Vista Regional Medical Center in reliance on this Authorization before it received my written notice of revocation.

I may contact Sierra Vista Medical Center's Privacy Team by mail at: 1010 Murray Ave. San Luis Obispo, Ca. 93405. I may contact the HIM Director by telephone at: 805-546-7634 or by email at Alyssa.debrum@tenethealth.com.

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 below, I hereby, knowingly and voluntarily, authorize Sierra Vista Regional Medical Center to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient **Date**

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

_____ _____ _____

Signature of Personal Representative **Description of Authority** **Date**

For Internal Use Only: The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records.

_____

Signature of employee validating identity