Antelope Valley Medical Center
*A facility of Antelope Valley Healthcare District*
1600 West Avenue J, Lancaster, CA 93534
www.avmc.org

# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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.

| **PATIENT INFORMATION** | | | | |
|---|---|---|---|---|
| Patient's Name: | Last | First | Middle Initial | Birth Date |
| | | | | |

I hereby authorize **Antelope Valley Medical Center (AVMC)** to release protected health information to:

| **USE AND DISCLOSURE OF HEALTH INFORMATION** | | | | |
|---|---|---|---|---|
| Authorized to Receive information: | | (Full Name of person or organization) | | |
| Address | (complete address) | City | State | Zip Code |
| | | | | |

**Specify Date/Time Period:**

Specify Date/Time period for information selected below:

From:_____ To: _____

**Information to be disclosed:**

| | |
|---|---|
| ☐ History & Physical | ☐ Discharge Summary |
| ☐ Operative/Procedure Report(s) | ☐ Emergency Department Reports |
| ☐ Diagnostic Report(s) (lab, radiology, EKG, etc.) | ☐ Progress Note(s) |
| ☐ Consultation Report(s) | ☐ Pathology Report(s) |
| ☐ Other (please specify) _____ | |

Sensitive Information will not be released unless specifically authorized below:

I understand and agree that the information below will be disclosed if I place my initials in the applicable space next to the type of information.

☐HIV Test Results_____ (initial) ☐ Behavioral Health Records _____(initial)

**Method of disclosure:** ☐ Mail ☐ Pick up ☐ Review/Inspect ☐ Fax to # _____

☐ Email _____

☐ Compact Disc (*only applies to electronic records*)

**Purpose:** The protected health information is being used or disclosed for the following purpose(s):

☐ Personal Use ☐ Continued Care ☐Other: _____

Unless revoked, this authorization expires one year from date signed or on this date: _____

| **SIGN BELOW:** | |
|---|---|
| Date | Signature (patient/legal representative) |
| If signed by someone other than the patient, state your legal relationship to the patient: | |
| Print Name | Phone # |
| Address | |

**FOR MEDICAL RECORDS DEPARTMENT USE ONLY**

Copy of this form to requestor: ☐ Yes ☐ No ☐ NA

Charges/Deposits discussed: ☐ Yes ☐ No ☐ NA

Verification and Witness: ID Verified

☐ Picture ID ☐ Wristband ☐ Signature Comparison

☐ Last 4 digits of social security number _____ ☐ Other:_____

| Witness Signature | Print name and title | Date |
|---|---|---|
| | | |

## NOTICE OF RIGHTS AND OTHER INFORMATION

### COMPLETING AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

To protect our patient's confidential medical information we must have a valid, complete and legible authorization to disclose their health information.

All sections of this authorization must be completely filled out before AVMC is permitted to disclose your protected heath information.

**Notice:**

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: Antelope Valley Medical Center – Medical Records Department 1600 West Avenue J, Lancaster, CA 93534.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

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

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA).

However, California law prohibits the person receiving my health information for making further disclosure of it unless another authorization for such disclosure is obtained from me unless such disclosure is specifically required or permitted by law.

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefit.

Requesting records using the AVMC patient portal is available for patient and their proxies.

If you currently have a patient portal account, you may access the secure site at, www.avmc.org/myavmc.