

Outgoing



AUTHORIZATION TO USE, DISCLOSE & RELEASE PROTECTED HEALTH INFORMATION

I authorize Providence Medical Institute to use and disclose a copy of the specific health information described below regarding:

Patient's Name: [] DOB: []
Patient/Representative Name: [] Phone: []

To be disclosed to: (Name of Recipient(s)): Hoosier Services Inc.
Recipient's Address: 18032 Lemon Drive, #C-618
City: Yorba Linda State: CA Zip: 92886
Phone: 800.882.4156 Fax: 800.882.4957

I am requesting information from the following facility(s):

Clinics Name (List) and Phone Number
Providence Madrona Primary Care
21311 Madrona Ave., Ste. 100-A Torrance, CA 90503 Tel: 310.792.4400 Fax: 310.542.5805

For the ranges of dates from: [] to: []

For information related to the following diagnosis or injury: []

Information to be disclosed:
[] Progress Notes [] Immunizations [] Diagnostic Reports (lab, x-rays, EKG, etc.)
[] Other (specify): []

For the purpose of: Life Insurance

Unless revoked, this authorization expires in 180 days or on this Date: []

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/AIDS testing/treatment ___ Mental Health specific visits
___ Genetic Testing ___ Drug/Alcohol specific visits

Patient Signature: [] Date: []
Representative Name: [] Date: []
Representative Signature: [] Relation to Patient: []

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I understand the following:

- I have the right to refuse to sign this form for authorization to disclose or release my protected health information. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign this authorization may affect my ability to receive health care services is if the health care services are research-related or solely for the purpose of providing health information to someone else and the authorization is needed to make that disclosure.
- There may be a fee associated with this request.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/ AIDS, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.
- I have the right to receive a copy of this signed authorization.
- I may revoke this authorization in writing at any time. If I revoke this authorization, the information described below may no longer be used or disclosed for the purposes described in the written authorization. The only exception is when PMI has taken action in reliance on the authorization or the authorization was obtained as a condition of insurance coverage.

To revoke this authorization, send a written statement that you are revoking this authorization along with a copy of this authorization to:

Release of Information Department
3460 Torrance Boulevard, 3rd floor
Torrance, CA 90503
Phone: (310) 792-6333 Fax: (310) 792-6390

Providence Medical Institute no longer prints or releases patient social security numbers unless required for billing. However, social security numbers may be included in patient information that is more than a few years old. The information you are authorizing to be released may include your social security number.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.