AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Today's Date: ____________________

Name of Patient: ______________________________ **Date of Birth:** ____________

DISCLOSURE OF HEALTH INFORMATION

(Please select one or both boxes) ☐ **Verbal** ☒ **Written Documents or Images**

I hereby authorize: TORRANCE MEMORIAL PHYSICIAN NETWORK to release to:

Hoosier Services Inc.

(Persons Name/ Doctors Name/Organization authorized to receive the information)

18032 Lemon Dr.,#C-618

(Address — street and unit number if applicable)

Yroba Linda	CA	92886
(City)	*(State)*	*(Zip code)*

800.882.4957	800.882.4156
(Fax Number)	*(Telephone Number)*

The following information:

a. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received including Mental health treatment information, HIV test results and Alcohol/drug treatment information. (A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act)

b. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received. Excluding the information marked below (check as appropriate)

- ☐ Mental health treatment information ____________ *(initial)*
- ☐ HIV test results _________ *(initial)*
- ☐ Alcohol/drug treatment information ____________ *(initial)*

c. ☐ Only the following specific records or types of health information. Include the dates of the specific records: ____

____

Any Limitations to the information to be given to the person receiving verbal or written information: ____

____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

MY RIGHTS

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

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

- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

  Attn: Privacy Officer
  Torrance Memorial Physician Network
  23326 Hawthorne, Suite 200
  Torrance, CA 90505

  You may contact us at:
  (310)784-4953 or tmpnprivacy.officer@tmmc.com

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

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

- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure 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 from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE

Today's Date: ____________________

This authorization expires on (date):____________________________ *(Forms renewed every 5 years)*

____
Name of Patient/Legal representative *(please print)*

____ ________________________________
Signature of Patient/Legal representative **Relationship to Patient**

**Note to provider that discloses health information pursuant to an authorization must communicate any limitation contained in the authorization to the recipient [Civil Code Section 56.14]. The required notification may be accomplished by giving the recipient a copy of the authorization form.*