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 Name _____ Account # _____
(Last Name) (First Name) (Middle Initial)

Date of Birth _____ Phone # _____

Authorization

I hereby authorize:

- ☐ Emanate Health Queen of the Valley Hospital
- ☐ Emanate Health Inter-Community Hospital
- ☐ Emanate Health Foothill Presbyterian Hospital
- ☐ Emanate Health Imaging (Glendora)
- ☐ Emanate Health Medical Care Foundation (Specify speciality clinic & city) _____
- ☐ Emanate Health 1206d Clinic (Specify speciality clinic & city) _____

To release to _____
(Persons / Organizations authorized to receive the information)

(Address) (City)

(State) (Zip Code) (Area Code) (Phone Number)

The following information: Date of Service: _____

- ☐ Complete Chart
- ☐ Pertinent Documents (Provider reports, Diagnostic tests)
- ☐ Other _____
- ☐ Discharge Summary
- ☐ Immunization Record(s)
- ☐ Pathology Report
- ☐ Itemized Billing
- ☐ Imaging CD (Radiology, Cardio, Cathlab)
- ☐ X-ray and Imaging Reports
- ☐ ST Video Recording ($10 fee)
- ☐ Laboratory Report

I specifically authorize release of the following information:

- ☐ Mental Health _____ (initial)
- ☐ Substance Treatment Record _____ (initial)
- ☐ HIV / Test Results _____ (initial)

Select the purpose of your request:

- ☐ Personal
- ☐ Continuation of Care
- ☐ Legal
- ☐ Insurance
- ☐ Other _____

EmanateHealth®

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

* C O R R *

Patient's Rights

- I may refuse to sign 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 may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the Health Information Management Department.
- My revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.

Duration of Authorization

This authorization will expire on the following date, event or condition _____ if I fail to specify an expiration date or event, this authorization will expire 6 months from the date on which it was signed.

Restrictions

Information disclosed pusuant 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 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 of patient or legal representative	Date / Time	Relationship to patient (if signed by Legal Representative)
Witness	Date / Time	