



**USC UNIVERSITY HOSPITAL**

**AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

|   |  |       |        |
|---|--|-------|--------|
| <b>Patient Name:</b>  | _____  | _____ | _____  |
|   | Last   | First | Middle |
| <b>Home Address:</b>  | _____  |       |        |
| <b>Home Telephone:</b>  | _____  |       |        |
| <b>Date of Birth:</b>   | _____  |       |        |
| <b>Specify Information to be Disclosed:</b>   |  |       |        |
| _____   |  |       |        |
| _____   |  |       |        |
| 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: |  |       |        |
| <input type="checkbox"/>  | Mental Illness   | _____ |        |
| <input type="checkbox"/>  | Developmental Disability   | _____ |        |
| <input type="checkbox"/>  | Psychotherapy Notes  | _____ |        |
| <input type="checkbox"/>  | HIV/AIDS Testing, Diagnosis, or Treatment (regardless of result)       | _____ |        |
| <input type="checkbox"/>  | Communicable Disease   | _____ |        |
| <input type="checkbox"/>  | Substance Abuse, Prevention or Treatment                               | _____ |        |
| <input type="checkbox"/>  | Sexual Assault   | _____ |        |
| <input type="checkbox"/>  | Child Abuse or Neglect   | _____ |        |
| <input type="checkbox"/>  | Genetic Testing  | _____ |        |
| <input type="checkbox"/>  | Domestic Abuse   | _____ |        |
| <input type="checkbox"/>  | Elder Abuse  | _____ |        |
| <input type="checkbox"/>  | Other  | _____ |        |
| <b>RECIPIENT: Name of person or class of persons to whom USC University Hospital may disclose my health information:</b> _____  |  |       |        |
| <b>ADDRESS: Address of the recipient or where my health information should be delivered:</b>  |  |       |        |
| <b>TERM: This Authorization will remain in effect:</b>  |  |       |        |
| <input type="checkbox"/>  | From the date of this Authorization until the ___ day of _____, 200__. |       |        |
| <input type="checkbox"/>  | Until USC University Hospital fulfills this request.                   |       |        |
| <input type="checkbox"/>  | Until the following event occurs                                       |       |        |

Other

PURPOSE: I authorize USC University Hospital 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 USC University Hospital discloses my health information to the recipient, USC University Hospital 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 USC University Hospital 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 USC University Hospital to inspect and/or obtain a copy of my health information, and that USC University Hospital 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 USC University Hospital; except, however, if my treatment at USC University Hospital is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case USC University Hospital 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 USC University Hospital'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 **USC University Hospital's** Privacy Office at the address listed below. The revocation will be effective immediately upon USC University Hospital's receipt of my written notice, except that the revocation will not have any effect on any

action taken by USC University Hospital in reliance on this Authorization before it received my written notice of revocation.

I may contact USC University Hospital's Privacy Office by mail at 1500 San Pablo St., Los Angeles, CA 90033, or by telephone at 323- 442- 5395 or by email at USC-Privacyofficer@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 USC University Hospital 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

12/27/04

USC UNIVERSITY HOSPITAL  
HEALTH INFORMATION MANAGEMENT  
1500 SAN PABLO STREET  
LOS ANGELES, CA 90033