Cancer Center
OF SANTA BARBARA with sansum CLINIC

AUTHORIZATION FOR USE / DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this form authorizes the use and/or disclosure of individually identifiable Protected Health Information (PHI) by the person(s) or entity identified herein and as consistent with State law and Federal regulations governing patient privacy and record confidentiality. To assist in the timely processing and delivery of your request, please fill out this form accurately and completely.

Part 1: AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

[*NOTE:* An administrative fee of $25.00 (+ $0.25 per page) applies to personal paper-based copies. Copies of last 2 years of your records are sent cost-free to outside providers when specified.]

I, _____, authorize the use and/or disclosure of my medical records as stored and maintained at Cancer Center of Santa Barbara with Sansum Clinic.

My Full Name: _____ My Phone Number: _____

My Current Address: _____

Patient Identifiers (DOB / Last 4 of SSN / MRN / Account No., *etc*.; *minimum of 2 identifiers required*):

(1) _____ (2) _____

***FROM*:** (**Name and address of provider/department where PHI is stored and maintained**)

_____

_____

***TO*:** (**Recipient of copies to be forwarded**, including address and phone number when available)

_____

_____

This Authorization applies only to the following records (*check **one or more** of the following*):

☐ **Last 2 years** of health information pertaining to my medical history, mental or physical condition, as well as treatment received during same period. [*OPTIONAL*] Except (*describe*): _____

_____

☐ Results of test(s) to detect the probability of Human Immunodeficiency Virus (HIV), which is the probable causative agent of Acquired Immune Deficiency Syndrome (AIDS).

☐ Psychiatric records ☐ Substance abuse records

☐ **Only** the following medical records or PHI, including any dates or events (*please describe*): _____

_____

Part 2 : IF ANOTHER REQUESTOR (NOT THE PATIENT) OR CANCER CENTER SEEKS AUTHORIZED RELEASE

My medical records or PHI will be used for the following purpose(s):

_____ Continuity of care
_____ Changing provider
_____ Insurance eligibility/benefits
_____ Legal or regulatory process/action; law enforcement
_____ Personal (at request of patient or patient representative)
_____ Other (*specify*): _____

I, the Patient, may inspect or obtain a copy of the medical records or PHI that I am being asked to release or disclose. I understand that treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this Authorization.

Part 3 - EXPIRATION DATE

This Authorization expires exactly one year from the effective date or on date indicated (MM/DD/YYYY), whichever comes first. **Expiration Date:**_____

Part 4 - RESTRICTIONS TO REQUESTOR

California law prohibits the Requestor from making further disclosure of PHI unless the Requestor obtains another authorization from the patient or such disclosure is specifically required or permitted by law.

NOTE TO PATIENT: *If you have authorized the use, release, and/or disclosure of your health information to someone who is not legally required to keep it confidential, it may be redisclosed and therefore may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.*

Part 5 - YOUR RIGHTS AS A PATIENT

(A) I may refuse to sign this Authorization.

(B) I may revoke this Authorization at any time. My revocation must be in writing and must be signed and dated by me or by my representative, and delivered to:

Cancer Center of Santa Barbara with Sansum Clinic
Attn: HIS – Release of Information, 89 S. Patterson Ave., Santa Barbara, CA 93111
HIS/ROI Tel.: (805) 692-6435 - HIS/ROI Fax: (805) 692-4699

(C) My revocation is effective upon receipt but will be void to the extent that the Requestor or others may have already acted in reliance upon this Authorization.

(D) I have the right to receive a copy of this Authorization.

Part 6 - PATIENT SIGNATURE / AUTHENTICATION

With my signature on this Authorization, I confirm that it reflects accurately my wishes and affirm that I understand it fully and completely.

Today's Date (**Effective Date**): _____ Time: _____ AM / PM [*circle which*]

Signature: _____ Patient / Patient Representative [*circle who*]

Patient Representative Identifiers (*minimum of two required; see Page 1 of this form.*):

(1) _____ (2) _____

If signature above belongs to patient representative, legal relationship to the patient:_____

Name/initials of receiving ROI or Clinic staff: _____ Date: _____

ENDNOTES

1 Patient is provided a copy of Authorization when it has been requested by a covered entity (*e.g.* Sansum) for its own use and/or disclosures.

2 The Requestor (*e.g.* Sansum Clinic/ROI/other third party requestor such as an outside provider) completes this form except Part 6, which must be completed by the patient or patient representative.

3. This Authorization form does not apply if the Requestor is seeking to use PHI (a) to conduct research-related treatment; (b) to obtain information in connection with individual eligibility or enrollment in a health plan of which the individual is not already a member; (c) to enable the Requestor to determine its obligation to pay a claim; or (d) to create health information to provide to a third party. Under no circumstances is the patient required to authorize the disclosure of psychotherapy notes by using this or any other form.

4, A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a nonprofit hospital plan, a health care service plan, or an employee benefit plan.