

# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

## DISCLOSURE STATEMENT

I hereby authorize:

Southwest Healthcare System (includes Rancho Springs & Inland Valley Medical Centers)

Temecula Valley Hospital

Other: \_\_\_\_\_

To release protected health information to the following person or entity:

Entity or Person: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

## HEALTH INFORMATION TO BE RELEASED

Pertinent Information for Continuing Care

History & Physical Exams  Radiology & Other Imaging  Consultation Reports

Laboratory Reports  Diagnostic Reports  Discharge Instructions

Operative Reports  Images  EKG/ECHO

Pathology Reports (X-rays, MRI, CT, etc ... )  ER Record

Billing Statements

Other: \_\_\_\_\_

I specifically authorize the release of the following information (check as appropriate):

Alcohol or drug treatment  HIV test results  Mental health treatment information  
information (other than psychotherapy notes)

## REQUESTED SERVICE DATES

Please indicate the date(s) and/or time period for the information selected above:

Most Recent Visit  Date(s): \_\_\_\_\_

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## PATIENT IDENTIFICATION



RI0020

INLAND VALLEY MEDICAL CENTER  
RANCHO SPRINGS MEDICAL CENTER  
TEMECULA VALLEY HOSPITAL



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## SIGNATURE

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM  
Printed Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Relationship: \_\_\_\_\_ (If not patient)

Completed at time of record pickup:

Record picked up by:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM  
Printed Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_ (If not patient)  
ID Type: \_\_\_\_\_ ID Number: \_\_\_\_\_  
ID Verified by: \_\_\_\_\_

For Office Use Only

Records released from

Medical Records       Laboratory       Radiology  
 Emergency Department  
 Nursing Unit, Unit Name: \_\_\_\_\_  
 Other: \_\_\_\_\_

ID Type: \_\_\_\_\_ ID Number: \_\_\_\_\_

Witness  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM  
Witness Printed Name: \_\_\_\_\_

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