Keck Medicine of University of Southern California
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Information

Patient's name: (Last) _____ (First) _____

Mailing address: _____

Email address: _____

Phone: _____ Date of Birth: _____

Information to be disclosed by Keck Medicine of USC:

Dates of service: from _____ to _____

( ) Physician reports and diagnostic results only
( ) Complete medical record
( ) Specific information: _____

Locations / Physicians of records to be released:

( ) Keck Hospital of USC ( ) USC Norris Cancer Hospital ( ) USC Verdugo Hills Hospital
( ) USC Care Medical Group (Please specify physician): _____

Highly Confidential Sensitive Information

By initialing next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the highly confidential information, if any such information will be used or disclosed pursuant to this authorization.

( ) Mental illness
( ) Developmental Disability
( ) Psychotherapy notes
( ) Substance abuse
( ) Genetic testing
( ) Gender affirming care
( ) Communicable disease
( ) HIV/AIDS
( ) Reproductive health
( ) Other: _____

Recipient Information

Recipient name: _____

Mode of delivery: ( ) email address: _____

( ) US Postal mail address: _____

( ) Fax number: _____

( ) Pick up from facility*: ( ) Keck Hospital of USC ( ) USC Norris Cancer Hospital ( ) USC Verdugo Hills Hospital

*I understand if I don't pick up within 5 business days, the hospital will shred the record copies and a new request will need to be submitted.

Term

This authorization shall remain in effect for a maximum of six (6) months from the date of signature, or until the _____ day of _____, 20 _____

Purpose

I authorize the use or disclosure of my protected health information (including highly confidential sensitive information authorized above, if any) during the term of this authorization for the following purposes:
( ) _____

( ) Health oversight activities
( ) Judicial or administrative proceedings
( ) Law enforcement
( ) Decedent, disclosure to coroners and medical examiners

I understand that once Keck Medicine of USC discloses my protected health information to the recipient, Keck Medicine of USC can't guarantee the recipient will not redisclose my protected 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 Keck Medicine of USC may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my protected health information.

I understand that I may at any time make a written request to Keck Medicine of USC to inspect and/or obtain a copy of my health information, and that Keck Medicine of USC will either, within five days for 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 protected 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; except, however, if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in this authorization, in which case Keck Medicine of USC 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 Keck Medicine of USC Health Information Mgmt. at HIMROI@med.usc.edu or 1500 San Pablo St. Rm 1206 Los Angeles, CA 90033.

I understand that this authorization will remain in effect until the terms of this authorization expires or I provide a written notice of revocation to Keck Medicine of USC's Office of Compliance at 1500 San Pablo St. Los Angeles, CA 90033. The revocation will be effective immediately upon Keck Medicine of USC's receipt of my written notice, except that the revocation will not have any action taken by Keck Medicine of USC in reliance on this authorization before it received my written notice of revocation.

I may contact Keck Medicine of USC Health Information Management Department at 626-293-2400.

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 Keck Medicine of USC to use or disclose my health information in the manner described above.

If patient is a minor or is otherwise unable to sign this authorization, patient's personal representative must sign below.

Name / ( ) Personal Representative Signature Date

For internal use only:

Identity of requester validated by government issued ID or comparison of signatures in the record.

Requestor identity validated by (employee signature)