CEDARS-SINAI®
KERLAN-JOBE INSTITUTE

Authorization for Use or Disclosure of Health Information

The 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. Your request will be processed and fulfilled within 4 – 7 business days from the day it is received.

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

_____

I, _____, hereby authorize Cedars-Sinai Kerlan-Jobe Institute to the use and/or disclosure of my health information as follows:

Person/Organizations authorized to use and/or disclose the information: _____

Person/Organizations authorized to receive the information: _____

Address or person/organization to receive the information: _____

This authorization applies to the following information:

_____ Entire Record _____ These specific dates only: _____

_____ X-Ray Films Dates: _____

Purpose of use or disclosure of information:

_____ To comply with court order _____ Required for insurance claim

_____ Application for insurance _____ For personal use

_____ Payment of a bill _____ For follow-up care

_____ To update medical records _____ Other: _____

Expiration: _____ (this authorization expires-insert date/event)

Restrictions: California law prohibits the requestor from making further disclosure of my health information, unless the requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

Patient's rights:

- I further understand that I have a right to receive a copy of the authorization upon my request
  Copy requested and received: □ YES □ NO _____ INITIAL
- 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 following address: _____
- My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization.
- I have the right to receive a copy of this authorization.

SIGNATURE:

Date: _____ Time: _____ (AM/PM) Signature: _____

(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient: _____

Witness: _____

(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected. California law prohibits recipients of your health information form redisclosing such information except with your written authorization or as specifically required or permitted by law.)

FAX TO: (310) 665-7281
Cedars-Sinai Kerlan-Jobe institute Correspondence Desk, Medical Record Department
Phone (310) 665-7249 Fax (310) 665-7281
Business Hours 9:00AM to 4:00PM