AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Providence Little Company of Mary Medical Center 4101 Torrance Blvd, Torrance CA 90503
Phone: (310) 303-5460 Fax: (310) 303-5469

Patient Name: _____ Birthdate: _____ Visit Date: _____
Address: _____ Phone: _____
Information to be released from: ***Providence Little Company of Mary Medical Center – Torrance***
Information to be released to:
Name: c/o Compex Legal Services
Address: 325 Maple Ave Torrance, CA 90503

Purpose of Release: ☐ Personal Use ☒ Other: Evaluation of a claim
Documents to be released: ☐Pertinent Information (Dictation, Test results)
☐HIV Results ☒Laboratory ☒Radiology ☐Pathology ☒ER Reports
☒Complete Record** ☒Other: Any and all medical and billing records
** A copy fee of 25 cents per page copied may be applicable, patient will be notified prior to copying.

Completion of this document authorizes the disclosure and/or use of individually identifiable health information consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization. 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. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to this facility. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance up this authorization. This authorization expires on: _____ or in six months if not specified. Neither treatment, payment, enrollment, nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

_____ Date: _____
Signature: Patient/Spouse/Financially Responsible Party

Printed Name: _____
Relationship: ☐Spouse ☐Parent ☐Child ☐Sibling ☐Guardian
☐Other: _____

Original: Medical Record Copy: Patient Form: Rev: 11-08, 5/09, 6-09, 8/12

Request Processed by: _____ Date: _____

Medical Record #: _____ Account #: _____
Notes: _____