St. Mary Medical Center

1050 Linden Avenue
Long Beach CA 90813

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient:_____ Date of Birth:_____

Other Names Used: _____ Telephone Number: _____

Medical Record or Account#:_____
(Hospital use only)

I AUTHORIZE : ***St. Mary Medical Center***
(Facility or other provider)

TO DISCLOSE TO: _____
(Persons/organizations authorized to ***receive*** the information)

at the following address:_____
(street, city, state and zip code)

the following information contained in the records specified below (check box and initial applicable lines below):

____Mental health or developmental disability treatment records (excludes "psychotherapy notes")

____Substance abuse treatment records

____HIV test results (This authorizes disclosure of laboratory test results only. **Note that your records may include information concerning your HIV status <u>even</u> if you do not initial this line.)**

☐ **THE FOLLOWING RECORDS,** specific types of health information, or records for the date(s) of treatment as specified [check applicable box(es)]:

- θ Billing Records
- θ Consultation Reports
- θ Discharge Summary
- θ Emergency Room Reports
- θ History and Physical
- θ Laboratory Tests
- θ Procedure Reports
- θ Progress Notes
- θ X-ray Reports
- θ Date(s):_____
- θ Other:_____

☐ **ALL RECORDS** regarding my treatment, hospitalization, and outpatient care. A separate authorization is required for the use or disclosure of psychotherapy notes or research health information.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
SMMC MR 1625 REVISED 2/04 PS