USC Verdugo Hills Hospital
Part of Keck Medicine of USC

1812 Verdugo Blvd., Glendale, CA. 91208
Office # (818) 952-3503 Fax # (818) 952-4640

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

*****FEES FOR PRODUCTION OF RECORDS**:***
$10.75 FOR 1ST PAGE & $0.25 for each additional page thereafter.

Patient Name:_____Date of Birth: _____

I hereby authorize the use and disclosure of protected health information about the above patient as follows:

A. Name of person, class of persons, or organization authorized to make the requested use or disclosure:_____
_____

B. Name of person, class of persons, or organization authorized to receive and use my protected health information:_____
_____

C. Description of patient's protected health information to be used or disclosed:_____
_____

D. Patient's protected health information is being used or disclosed for the following purpose(s):_____
_____
_____

I understand that I have the following rights with respect to this Authorization:

1. The recipient of the protected health information is prohibited from redisclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law.
2. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits.
3. *USC Verdugo Hills Hospital* will provide me with a copy of this Authorization.
4. I may revoke this Authorization at any time by mailing or personally delivering a signed, written notice of revocation to:

   USC Verdugo Hills Hospital
   1812 Verdugo Blvd
   Glendale, CA. 91208
   ATTN: HIM Department

   Such revocation will be effective upon receipt, except to the extent that the recipient has taken action in reliance on this Authorization.

5. I am entitled to notice if *USC Verdugo Hills Hospital* will use or disclose the protected health information for marketing and receive payment for the use or disclosure of my protected health information.

This Authorization will expire on: _____

_____	_____
Signature of Patient/Personal Representative*	Personal Representative's Authority to Act on Patient's Behalf
_____	_____
Printed Name	_____
_____	_____
Date	Address and Telephone Number of Patient/Personal Representative

*The home "Personal Representative" is any of the following:

- For an incompetent adult:
  - A conservator of the patient's person
  - An agent appoint by the patient under a power of attorney for health care

- For a minor who does not have special legal authority to sign an authorization:
  - Parent
  - Guardian
  - Any other person *in loco parentis*

- Any other individual who has the legal authority to make health care decisions on the patient's behalf (e.g., person who is the next-of-kin to a resident in a skilled nursing facility; person legally obligated to financially support patient); or

- An executor or administrator of the patient's estate or any beneficiary who stands to inherit property from the patient, if the patient is deceased.