PACIFIC COAST HOSPICE

Authorization for PHI Disclosure Form

Patient Information

FULL PATIENT NAME	DATE OF BIRTH	SSN
ADDRESS LINE 1	ADDRESS LINE 2	TELEPHONE

I hereby authorize PCH USA, LLC dba Pacific Coast Hospice to disclose my protected health information for the purpose of .....

Covered Entity

NAME OF PERSON/"COVERED ENTITY"	FULL ADDRESS	TELEPHONE

Information To Be Shared

☐ **All of the following in my medical record**

☐ Discharge Summary	☐ RN/CNA/MSW/Chaplain Notes	☐ Inpatient Notes	☐ Lab/Pathology Reports
☐ Radiology Reports & Images	☐ Medication List	☐ Office or Clinic Notes	☐ Plan of Care
☐ Therapy Notes	☐ Billing Records	☐ Immunizations	☐ Photos

Time Period Covered

☐ All records within one year from date of signature below ☐ Other Period:

Delivery

☐ Pickup ☐ Mail to Recipient ☐ Fax to Recipient

My authorization is valid for one year from the date of my signature below, unless I specify a different date here:
My Personal Representative or I may revoke this authorization at any time by providing written notice as specified in the Notice of Privacy Practices; however, my revocation will not apply to any previously released information.
I understand that once this information is shared with the recipient I specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations.
I understand that this request will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. The only circumstance where refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

Sensitive Information

This form authorizes Covered Entity to release the following types of information UNLESS I place my initials in the space provided:

___ psychiatric treatment records ___ sexually transmitted disease (STD) treatment ___ substance use disorder treatment
___ genetic testing ___ HIV/AIDS test results

Acknowledgement

Patient/Authorized Rep. Signature .....Date.....

Print Patient or Rep. Signing.....Description of Rep. Authority .....