

Patient Information

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

To Covered Entity

..... NAME OF PERSON/"COVERED ENTITY" FULL ADDRESS TELEPHONE
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I hereby request the above named "Covered Entity" to provide to PCH USA, LLC dba Pacific Coast Hospice "Recipient" my protected health information for the purpose of Admission and/or Treatment under Hospice and/or Palliative Care.

Information To Be Shared

All of the following in my medical record

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Emergency Dept Notes | <input type="checkbox"/> Inpatient Notes | <input type="checkbox"/> Lab/Pathology Reports |
| <input type="checkbox"/> Radiology Reports & Images | <input type="checkbox"/> Medication List | <input type="checkbox"/> Office or Clinic Notes | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Therapy Notes | <input type="checkbox"/> Billing Records | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Photos |

Time Period Covered

- All records within two years from date of signature below Other Period:

Delivery

- Pickup Mail to Recipient Fax to Recipient Secure Portal <https://pchusa.org/provider>

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:

- | | | |
|--|---|---|
| <input type="checkbox"/> psychiatric treatment records | <input type="checkbox"/> sexually transmitted disease (STD) treatment | <input type="checkbox"/> substance use disorder treatment |
| <input type="checkbox"/> genetic testing | <input type="checkbox"/> HIV/AIDS test results | |

Acknowledgement	
Patient/Authorized Rep. Signature	Date
Print Patient or Rep. Signing.....	Description of Rep. Authority