**TENET HEALTHCARE CORPORATION (hereinafter "Organization")**
**AUTHORIZATION TO USE AND DISCLOSE**
**PROTECTED HEALTH INFORMATION**

1

Last First Middle

**Patient Name:**

**Home Address:**

**Home Telephone:**

**Date of Birth:**

**Social Security Number:**

**Account Number(s):**

**Hospital/Facility:** Doctor's Medical Center of Modesto

2 **Specify Information to be Disclosed:**

- ☐ Billing records for date(s) of service:
- ☐ Medical records for date(s) of service:
- ☐ Other:

3 By applying a check next to a category of ***highly confidential*** information listed below and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ Mental Illness
- ☐ Development Disability
- ☐ Psychotherapy Notes
- ☐ HIV/AIDS Testing, Diagnosis or Treatment
- ☐ Communicable Disease
- ☐ Substance Abuse, Prevention or Treatment
- ☐ Sexual Assault
- ☐ Child Abuse or Neglect
- ☐ Genetic Testing
- ☐ Domestic Abuse
- ☐ Elder Abuse
- ☐ Other:

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4 **RECIPIENT**: Name and address of person(s) or class of persons to whom Organization may disclose my health information: _____

_____

Address of the recipient or where my health information should be delivered:

_____ Phone: _____

_____ Fax: _____

5 **TERM/EXPIRATION**: This Authorization will remain in effect and shall not expire until:

- ☐ From the date of this Authorization until the ___ day of _____, 200____.
- ☐ Organization fulfills this request.
- ☐ The following event occurs _____
- ☐ Other _____

6 **PURPOSE**: I authorize the Organization to use or disclose my health information (including the highly confidential information that I selected above, if any) during the term of this Authorization for the following specific purpose(s):

- ☐ At the request of the patient.
- ☐ Legal Purposes.
- ☐ Claims Purposes.
- ☐ Other _____

7 I understand that once the Organization discloses my health information to the recipient, the Organization cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable law governing the use and disclosure of my health information. I understand that the Organization may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

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| | |
|---|---|
| 8 | I understand that I may at any time make a written request to the Organization to inspect and/or obtain a copy of my health information, and that the Organization will within thirty (30) days of receiving such written request, either grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial. |
| 9 | I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of my treatment at Organization; except, however, if my treatment at the Organization is for the sole purpose of creating health information for disclosure to the recipient(s) identified in this Authorization, in which case the Organization may refuse to treat me if I do not sign this Authorization. |
| 10 | I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide written notice of revocation to Organization's Privacy Office at the address listed below. The revocation will be effective immediately upon Organization's receipt of my written notice, except that the revocation will not have any effect on any action taken by Organization in reliance on this Authorization before it received my written notice of revocation. |
| 11 | I may contact the Organization's Privacy Office by mail at: 1500 S. Douglass Rd, Anaheim, CA 92806, by telephone at (714) 704-9734, or by e-mail at mike.novick@tenethealth.com. |
| 12 | I understand that, at any time during which this Authorization is in effect, I may make a written request to the Organization to receive a copy of this Authorization. Such written request shall be made to the Organization's Privacy Office as identified above. |

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13 **I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize the Organization to use or disclose my health information in the manner described above.**

| | |
|---|---|
| **Signature of Patient*** | **Date** |

***If the Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signature:**

| | |
|---|---|
| **Printed Name of Personal Representative** | **Description of Authority** |
| **Signature of Personal Representative** | **Date** |

***FOR INTERNAL USE ONLY:*** the identity of the requestor has been validated, as notated below.

| | |
|---|---|
| Method of validating identity | |
| Signature of Organization employee validating identity | Printed Name |