Authorization for Use or Disclosure of Health Information

Please complete both sides.
Failure to provide all information may invalidate this Authorization.

Patient Information:			
Last Name:	First Name:	MI:	DOB:

Address:	City:	State:	Zip:
Telephone:	Email:		

Release From:	***Release To:***
I hereby authorize the following person/entity to release my information: Person/Entity:_____ Address:_____ City/State/Zip:_____ Phone:_____ Fax: _____	My medical records may be released to: Person/Entity:_____ Address:_____ City/State/Zip:_____ Phone:_____ Fax: _____

Purpose:

The release is authorized for the following purpose(s):
☐ Continuing Care ☐ Legal ☐ Insurance ☐ Personal Use
☐ Transfer of Care to New PCP ☐ Transfer of Care to New OB
☐ Other: _____

Information to Release:

☐ Lab Results ☐ X-Ray Results ☐ Progress Notes ☐ OB Records ☐ Referral Reports

☐ Other (Specify):_____

☐ All Medical Records in the specified date range, *except:*_____

Date Range of Records Requested:	From:	To:

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Restricted Information:

I understand the information to be released or disclosed may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), substance abuse, and/or mental health. I authorize the release or disclosure of this type of information, except:

_____.

NOTE: A separate authorization is required for behavioral health records and psychotherapy notes.

Delivery Instructions:

___ Mail___Fax records directly to person/entity specified above
___Call patient when records are ready for pick up.
___Patient/Representative authorizes_____to pick up the copies.
___Other instructions: _____

Expiration:

Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, or one year from the date signed, unless otherwise specified:

_____.

Notice of Rights:

1. If I refuse to sign this authorization, my refusal will not affect my ability to obtain treatment.
2. I may inspect or obtain a copy of the health information requested in this authorization.
3. I may revoke this authorization at any time in writing, signed by me or on my behalf, and delivered to Borrego Health, P.O. Box 2369 Borrego Springs, CA 92004.
4. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to Borrego Health's receipt of the revocation.
5. I have a right to receive a copy of this authorization.
6. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by the federal privacy rule (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

Signature:

Signature of Patient or Legal Representative: _____
Date:_____Relationship (if Legal Representative): _____

For Office Use Only
Released by:_____ #Pages_____