hoag
Medical Group
A member of the St. Joseph Hoag Health alliance

(INCOMING RECORDS) AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization.

Please review all gray shaded areas.

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Name: _____ Date of Birth _____

REQUESTING RECORDS FROM?

I hereby authorize the following office to release my records:

Name/Facility: _____ Attention: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

WHERE TO SEND YOUR RECORDS?

Name/Facility: Hoag Medical Group
Attention: Medical Records

☐ 1401 AVOCADO AVE., STE 303 Newport Beach, CA 92660	(949) 717-0072	(949) 759-0116
☐ 16300 SAND CANYON., STE 311 Irvine, CA 92618	(949) 791-3101	(949) 791-3176
☐ 19582 BEACH BLVD., STE 360 Huntington Beach, CA 92648	(714) 477-8001	(714) 477-8002
☐ 19582 BEACH BLVD., STE 250 Huntington Beach, CA 92648	(714) 477-8020	(714) 477-8022
☐ 26671 ALISO CREEK RD., STE 101 Aliso Viejo, CA 92656	(949) 791-3104	(949) 791-3181
☐ 26671 ALISO CREEK RD., STE 200 Aliso Viejo, CA 92656	(949) 791-3105	(949) 791-3183
☐ 4870 BARRANCA PKWY., STE 300 Irvine, CA 92604	(949) 791-3102	(949) 791-3147
☐ 4900 BARRANCA PKWY., STE 103 Irvine, CA 92604	(949) 791-3103	(949) 791-3167
☐ 510 SUPERIOR AVE., STE 200B Newport Beach, CA 92663	(949) 791-3001	(949) 791-3096

WHAT RECORDS TO SEND?

Please send records from the following date range: from _____ to _____.
***If no dates are entered only the last 2 years will be released**

Please send the following types of records:

☐ Labs
☐ History and Physical
☐ Progress Notes
☐ Consultation Notes
☐ All health information pertaining to any medical history, physical condition, and treatment received.
☐ Other: _____

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AUTHORIZATION TO RELEASE STATUTORILY PROTECTED INFORMATION:

I specifically authorize release of the following information (check and initial as appropriate):

☐ Mental health treatment information Initial if requesting:_____
☐ HIV test results Initial if requesting:_____
☐ Alcohol/drug treatment information Initial if requesting:_____

*If not checked and initialed, the records containing such information can NOT be released.

WHAT IS THE PURPOSE OF REQUESTING THESE RECORDS?

☐ Continuing Care
☐ Patient Request
☐ Legal
☐ Insurance
☐ Other_____

***If no box is checked; this will be treated as a continued care request.**

WHEN WILL THIS REQUEST EXPIRE?

This Authorization expires: [insert date]_____

***If no Date is given; this authorization will expire 6 months from the signature date.**

WHAT ARE MY RIGHTS?

- I may refuse to sign this Authorization. If I refuse to sign this Authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the address specified in the "REQUESTING RECORDS FROM" section above. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.
- I have a right to receive a copy of this Authorization. Copy requested and received:
  ☐ Yes ☐ No Initial: Date:
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURES

Patient Signature:_____ Date:

THIS SECTION MUST BE FILLED OUT IF THE PATIENT DID NOT SIGN ABOVE

Legal Representative Signature: _____ Date:
State your legal relationship to the patient and why you have the authority to act for the patient:

(The legal representative must submit proof of legal representation)

Witness Signature:_____ Date: