PLEASE INDICATE HOW TO RELEASE THIS INFORMATION:
□ Electronic Copy (encrypted and provided on CD)
□ Health Information Exchange (HIE) □ Paper Copy
□ Verbal Communication Only (MH)

Health Information Management
823 Gateway Center Way
San Diego, CA 92102
Phone: (619) 515-2368 Fax: 619-269-0132

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: ____________________

Date of Birth: ____________ MR #:____________

Address: ____________________

Phone: ____________________

Place Patient Label here

Please **SEND** information **TO:**

Name of physician, hospital or other: ____________________
Street Address: ____________________ City/State/Zip: ____________________
Phone: ____________________ Fax: ____________________

DESCRIPTION OF EACH PURPOSE OF THE REQUESTED USE OR DISCLOSURE:
☐ Patient Care ☐ Self ☐ Other: (Please specify) ____________
☐ Insurance Claim ☐ Legal

A DESCRIPTION OF THE INFORMATION TO BE DISCLOSED: ☐ Lab/Pathology Reports ☐ Consults/Procedures/EKG
☐ Immunizations ☐ Progress Notes ☐ Labor/Delivery Records ☐ Newborn Records/Screening
Imaging (X-ray/US/CT/MRI): ☐ Reports and/or ☐ Images ☐ Billing ☐ Other: ____________

FOR THE FOLLOWING PERIOD OF TIME: (SPECIFY DATES TO BE RELEASED)
From: ____________ (date) To : ____________ (date)

THIS AUTHORIZATION SHALL BEGIN IMMEDIATELY AND REMAIN VALID UNTIL: (To be completed by staff only)
(Date) ____________________

I AUTHORIZE THE FOLLOWING RECORDS:

☐ MEDICAL INFORMATION **☐ MENTAL HEALTH INFORMATION**

____________________ ____________________
Signature Date Signature Date

☐ DRUG/ALCOHOL **☐ HIV & RELATED INFORMATION**

____________________ ____________________
Signature Date Signature Date

I have the right to revoke this authorization by sending a signed notice stopping this authorization to the health information management department at my primary care medical home. The authorization will stop further release of information on the date my valid revocation request is received at the health information management department.

I am signing this authorization voluntarily; I understand my treatment will not be affected if I do not sign this authorization.

Under California Law, the recipient of protected health information under the authorization is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law. If the organization or person I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that I have the right to receive a copy of this authorization.

Signature: ____________________
(Patient/legal representative) Date Time

If signed by other than patient, indicate relationship: ____________________
Witness: ____________________

PHOTOCOPY VALID AS ORIGINAL

FAMILY HEALTH CENTERS OF SAN DIEGO

REVOCATION OF AUTHORIZATION FOR RELEASE OF INFORMATION

(PLEASE COMPLETE ONLY IF VOIDING A PREVIOUSLY SIGNED CONSENT)

Patient Name: ______________________________ Date of Birth: ____________ MR #:_____________

Address: __________________________________ City/State/Zip: ______________________________

Phone: _____________________________________

In accord with provisions of the Notice of Privacy Practices, I hereby revoke the

- ◻ **Authorization to send information to ___________________________ dated ___________________**
- ◻ **Authorization to obtain information from _______________________ dated ___________________**

Signature: ____

(Patient/legal representative) Date Time

If signed by other than patient, indicate relationship:____

Witness: ____

*********************************For Office Use Only*******************************

Date Revocation Received: ____

- ◻ Identity of individual and/or legal representative verified

______________________________ ______________________________

Medical Record Number Clerk Initials