Seaside Family Medicine

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(A separate authorization is required for release of psychotherapy notes)

Fax: 949-543-2631

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone Number: _____ Social Security Number: _____

By signing this authorization form, I authorize the person(s) and/or organization described below to use and/or disclose my health information in the manner described. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) described below who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision to sign this authorization. I have signed this form voluntarily in order to document my wishes regarding the use and/or disclosure of health information described below.

Section One- Description of Health Information I Authorize to be Used or Disclosed

The following is a specific description of the health information I authorize to be used and/or disclosed from the time period of: _____ to _____

_____ Physician Notes _____ Nursing Notes _____ Cardiology Reports

_____ History& Physical _____ Xray Reports _____ Discharge summaries

_____ Lab reports _____ Consultation reports _____ Pharmacy Reports

_____ other (please specify): _____

Section Two- Persons/Organizations Authorized to Receive, Use, or Disclose Information

I authorize the following person(s) and/or organization(s) to use, receive, or disclose information indicated above for the purposes listed in Section Three of this form:

_____

_____

Section Three- Description of Purpose for Use

I authorize my health information to be used and/or disclosed for following purpose:

_____

_____

Section Four- Your Rights in Respect to this Authorization

- Right to revoke- I understand I have the right to revoke this authorization at any time. The request to revoke must be provided in writing.
- Right to inspect or copy the information being disclosed- I understand that I have the right to inspect or copy the information I have authorized to be disclosed. I may arrange to inspect my health information or obtain copies by contacting the Seaside Chief Operating Officer. I understand that the law allows for Seaside to charge a fee for copies of medical records.
- Right to receive a copy of this authorization- I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of it.

This authorization is effective on the date of signature and will remain in effect until: _____

(Date)

I, _____, have had the opportunity to review and understand the content of this form. By signing this form, I am confirming that it accurately reflects my wishes

_____ _____

(Patient's Signature) (Date)

If not signed by patient or patient is unable to sign, please complete the following:

Patient is unable to sign because: _____

Name of Personal Representative: _____

Relationship to Patient: _____

Authority of Representative (eg, healthcare power of attorney, guardian, beneficiary of deceased patient):

_____

Address: _____ Telephone Number: _____

Signature of Representative: _____ Date: _____