Dignity Health.
Pacific Central Coast
Health Centers

Medical record # _____
Account #_____
(Internal use only)

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of your health information. Please read the following carefully and complete the requested information below. **There may be fees associated with your request.** The purpose and delivery format of your request may determine the amount of such fees.

Name of Patient: _____ Date of Birth: _____

Other Names Used: _____ Telephone Number: _____

Medical Record or Account#: _____

I AUTHORIZE: _____
(Clinic or Provider)

TO DISCLOSE TO: _____
(Persons/organizations authorized to ***receive*** the information)

at the following address: _____
(Street, city, state and zip code)

THE FOLLOWING RECORDS, specific types of health information, or records for the date(s) of treatment as specified [check applicable box(es)]:

☐ All Medical Records Available ☐ Immunization Records

☐ X-ray Reports ☐ Laboratory Test Results

☐ Office Visit Notes ☐ Other: _____

Specified Treatment Date(s): _____
(If dates are not specified, records from the last 2 years will be provided)

The following classes of information are protected by special privacy laws and access may be subject to special rules or may be restricted under certain circumstances. If you are requesting access to records related to any of the following, additional authorization is required. Please initial each applicable item to confirm your request.

_____ Mental health treatment information.
Initial

_____ Substance abuse treatment information.
Initial

_____ HIV test results. This authorizes disclosure of laboratory test results only.
Initial

PURPOSE: The purpose and limitations (if any) of the requested use or disclosure is:

- ☐ At the request of the patient or personal representative for personal use; ***OR***
- ☐ For continuation of care; ***OR***
- ☐ Other: Please describe _____

I request that the records be delivered in the following format (choose one):

☐ Paper ☐ On Encrypted CD ☐ Electronic Delivery (Fastest format)

☐ Fax (to Facility or Provider only) Facility or Provider Fax #: _____

☐ Other _____

NOTE: Electronic delivery requires a valid email address. Please print your email address:

_____

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified: _____
(Insert date)

MY RIGHTS:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and submit to Pacific Central Coast Health Center. My revocation will take effect upon receipt, except to the extent that others have taken action in reliance upon this authorization.
- I have a right to receive a copy of this authorization

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).

SIGNATURE: _____ Date: _____
(Patient or personal representative)

_____ _____
Print name of personal representative Relationship to patient

Patient/Representative Identification Verified. Initials: _____

I understand that I have the right to receive a copy of my medical records for my own personal use and any applicable processing fee is due and payable upon request. Copy Requested: ☐Yes ☐No