(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.

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.

Patient Name: ______________________________ Date of Birth: ______________

REQUESTING RECORDS FROM?

I hereby authorize the following office to release my records:

Name/Facility: ______________________ Attention: ______________________

Phone: ______________________ Fax: ______________________

Street Address: ______________________ City: ____________ State: _____ Zip: ________

WHERE TO SEND YOUR RECORDS?

Name/Facility: Hoag Medical Group/Hoag Urgent Care

Requesting Provider: ______________________

Phone #: ______________________

Fax #: ______________________

Aliso Viejo

- ☐ 26671 Aliso Creek Rd. #101, Aliso Viejo, CA 92656
- ☐ 26671 Aliso Creek Rd. #200, 202 & 206 Aliso Viejo, CA 92656

Anaheim

- ☐ 5630 E Santa Ana Canyon Rd#100, Anaheim, CA 92807

Costa Mesa

- ☐ 1170 Baker St. #H1, Costa Mesa, CA 92626

Fountain Valley

- ☐ 8970 Warner Ave. Fountain Valley, CA 92708

Huntington Beach

- ☐ 5341 Warner Ave. Huntington Beach, CA 92649
- ☐ 5355 Warner Ave. #102, Huntington Beach, CA 92649
- ☐ 19582 Beach Blvd. #180, Huntington Beach, CA 92648
- ☐ 19582 Beach Blvd. #250 & 350 Huntington Beach, CA 92648

Irvine

- ☐ 4870 Barranca Pkwy. #300, Irvine, CA 92604
- ☐ 4900 Barranca Pkwy., Irvine, CA 92604
- ☐ 6340 Irvine Blvd., Irvine CA 92620
- ☐ 8607 Irvine Center Dr., Irvine, CA 92618
- ☐ 16100 Sand Canyon Ave. #245, Irvine, CA 92618
- ☐ 16205 Sand Canyon Ave, Irvine, CA 92618
- ☐ 16300 Sand Canyon Ave. #311, Irvine, CA 92618

Laguna Beach

- ☐ 364 Ocean Ave. Laguna Beach, CA 92651

Newport Beach

- ☐ 415 Old Newport Blvd. #101, Newport Beach, CA 92663
- ☐ 500 Superior Ave. #160, Newport Beach, CA 92663
- ☐ 500 Superior Ave. #270, Newport Beach, CA 92663
- ☐ 360 San Miguel Dr. #105, Newport Beach, CA 92660
- ☐ 400 Newport Center Drive #401, Newport Beach, CA 92660
- ☐ 510 Superior Ave. #200B-D, Newport Beach, CA 92263

Tustin

- ☐ 15000 Kensington Park Dr. #170, Tustin, CA 92782
- ☐ 15000 Kensington Park Dr. #200 & 250, Tustin, CA 92782
- ☐ 2560 Bryan Ave. #A, Tustin, CA 92782

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
- ☐ Progress Notes
- ☐ History and Physical
- ☐ Consultation Notes

(Incoming Records)

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

☐ All health information pertaining to any medical history, physical condition, and treatment received

☐ Other ____

____

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 **CANNOT** be released.

WHAT IS THE PURPOSE OF REQUESTING THESE RECORDS?

☐ Continuing Care ☐ Patient Request ☐ Other ______________________

☐ Insurance ☐ Legal ______________________

***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).

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: ____________________