(Outgoing 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: ____________

*For pediatric patients, include mother's maiden name ____________________

REQUESTING RECORDS FROM?

I hereby authorize Hoag Medical Group / Hoag Urgent Care to release my records:

Phone: ____________________ Fax: ____________________

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

To release my medical records to:

WHERE TO SEND YOUR RECORDS?

Name/Facility: ____________________ Attention: ____________________

Phone: ____________________ Fax: ____________________

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

WHAT RECORDS TO SEND?

Please send records from the following date range: from ____________ to ____________

Please send the following types of records:

- ☐ All Health Information
- ☐ Progress Notes
- ☐ Surgeries
- ☐ History and Physical
- ☐ Consultation Notes
- ☐ Immunizations
- ☐ Labs
- ☐ 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.

(Outgoing Records)

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WHAT IS THE PURPOSE OF REQUESTING THESE RECORDS?

☐ Continuing Care ☐ Patient Request ☐ Other ____
☐ Insurance ☐ Legal ____

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: ____________________