Family Medical Group

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information

Patient Name _____ Date of Birth_____
Last First

Address:_____ City:_____ State:_____ Zip:_____

Phone: _____

Purpose of Requested Use or Disclosure (tell us how you will use the record)

☐ Transfer of Care ☐ Per my request ☐ insurance

☐ Other: _____

Type of Access Requested (please check only one)

☐ Paper copy ☐ CD

Authorization- I hereby authorize: (tell us who will be releasing records)

_____

Name of hospital, physician, Healthcare Facility

_____

Address city state zip

_____

Phone Fax

To Release my health information to: (tell us who records are going to)

FAMILY MEDICAL GROUP

Name of Person, hospital, physician, Healthcare Facility

911 EAST TUOLUMNE ROAD TURLOCK CA 95382

Address city state zip

209-668-4101 **209 667-5479**

Phone Fax

Information Disclosure (tell us what information you need)

Information to be disclosed for the following date range: ____ to ____

☐ Clinical Notes

☐ Outside Records (specify Provider Name or Medical Group):_____

☐ Radiology Report(s) Specify): ☐ X-ray ☐ ultrasound ☐ CT Scan ☐ MRI

☐ Mammography

☐ Laboratory Test(s) ☐ Billing Records ☐ Other: _____

Special Authorization (initial to give us permission to release the following sensitive information)

☐ HIV test results _____ (initial) ☐ Substance abuse _____ (initial)
☐ Behavioral Health _____ (initial) ☐ Psychiatry _____ (initial)

Expiration

This authorization shall become effective immediately and shall remain in effect for one year from the date signed unless a different date is specified here: _____

Restrictions

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPPA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law. This protection does not extend to recipients outside the state of California.

Your Rights

I may refuse to sign this authorization and my refusal will not affect my ability to obain treatment or payment

I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to Family Medical Group. My revocation will be effective upon receipt, but will have no impact on uses or disclosure made while my authorization was valid.

I have a right to receive a copy of this authorization (required if authorization is requested for the provider's use or disclosure of health information).

I may inspect and obtain a copy of the health information of which I am authorizing the use of disclosure of my health information. Copies will be available in 48 hours for Records excluding Behavioral Health Records which can take up to 15days.

Signature: (As required by law)

SIGNATURE: _____ Date: _____
(Patient/Legal Representative)

Print Name: _____
(patient)

If signed by anyone other than the patient, print name and relationship:

Name: _____ Relationship: _____
(Legal Representative)