Completion of this document authorizes the use or disclosure of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.
Failure to provide all information requested may invalidate this Authorization.

USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth** _____
(Please print)

I hereby authorize the use or disclosure of my health information as follows:
Persons/Organizations authorized to *release* (use or disclose) the information:[1] _____
(TCMC or other Entity)

Persons/Organizations authorized to *receive* the information (name and address of entity):

_____

_____

_____
Phone Number (with area code)

This Authorization applies to the following specific information to be disclosed (select from the following).[2]:

☐ All health information pertaining to any medical history, mental or physical condition and treatment received. Dates include: _____
[Optional] Except for these specific limitations:
_____

☐ Only the following records or specific types of health information. Dates include:_____

- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Emergency Dept Report
- ☐ Laboratory Tests
- ☐ History/Physical Report
- ☐ Operative/Procedure Report
- ☐ EKG
- ☐ X-Ray Reports
- ☐ Other (please specify) _____

I understand that this will include information relating to (check if applicable):

- ☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection
- ☐ Psychiatric Care (patient to initial here _____)
- ☐ Treatment for alcohol and/or drug abuse.

EXPIRATION

This Authorization expires [on the following specific date]: _____

RESTRICTIONS

I understand that California law prohibits the recipient of my health information pursuant to this authorization from making further disclosure of my health information unless the Recipient obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS

I understand that I may refuse to sign this Authorization.
I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: 4002 Vista Way Oceanside, CA 92056. Attn: Medical Records/Health Information.
I understand that my revocation will be effective upon receipt, but will not affect any use or disclosures completed prior to receipt of the revocation.

AUTHORIZATION FOR USE OR DISCLOSURE

ADDITIONAL RIGHTS AND REQUIREMENTS IF REQUESTOR SEEKS THIS AUTHORIZATION

I understand that if Requestor seeks this authorization:

1. My health information will be used for the following purpose(s): ☐ Continuing Medical Care
   ☐ Insurance ☐ Legal ☐ Other (Please specify) _____
2. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
3. I must receive a copy of this Authorization.
4. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. However, this does not apply if the Requestor is seeking to use the information as follows: (i) to conduct research-related treatment; (ii) to obtain information in connection with my eligibility or enrollment in a health plan of which I am not already a member; (iii) to enable the Requestor to determine its obligation to pay a claim; or (iv) to create health information to provide to a third party. Under no circumstances, however am I required to authorize the disclosure of psychotherapy notes.
5. If this box ☐ is checked, I understand the Requestor may receive compensation or other remuneration directly or indirectly for the use or disclosure of my information

SIGNATURE

Signature _____ Date/Time _____AM/PM
[Patient/representative/spouse/financially responsible party]

If signed by someone other than the patient, state your legal relationship to the patient[5]:

_____

Witness: _____

(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.)

Authorization for Use or Disclosure of Health Information – Footnote references

[1] If the Authorization is being requested by the entity holding the health information, then such entity shall be referred to as the Requestor throughout this form.
[2] This form may not be used to release both psychotherapy notes and other types of health information (*see 45 CFS § 164.508(b)(3)(ii)*. If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.
[3] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 CFR § 164.508(d) (I), (e) (2)).
[4] The Requestor is to complete this section of the form.
[5] A spouse or financially responsible party may only authorize release of medical information for use in the following:
   a. to process an application for the patient
   b. as a spouse or dependent for the following:
      a. a health insurance plan or policy
      b. a nonprofit hospital plan
      c. a health care service plan or
      d. an employee benefit plan

For TCMC Medical Records/Health Information use Only

MRUN: _____ **Date Received:** _____

Date of Birth: _____ **Visits to be Included:** _____

SS#: __ __ __ – __ __ – __ __ __ __ _____

Telephone #: _____ _____

Distribution: ☐ **Mail** ☐ **Pick-up** ☐ **Other** _____ **Completed by:** _____
Signature **Date**