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:
Person/Organization authorized to *release* (use or disclose) the information: Tri-City Medical Center
(TCMC or other Entity)
Person/Organization authorized to *receive* the information (name and address of entity):
Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Fax: _____ Email: _____

I would like the Health Information:
☐ Mailed as: ☐ CD ☐ Paper ☐ Faxed ☐ E-Mail ☐ Secured ☐ Unsecured

**This Authorization applies to the following specific information to be disclosed (select from the following).[1]:**

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

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

| | | |
|---|---|---|
| ☐ Discharge Summary | ☐ Laboratory Tests | ☐ EKG |
| ☐ Consultation Reports | ☐ History/Physical Report | ☐ X-Ray Report |
| ☐ Emergency Dept Report | ☐ Operative/Procedure Report | |

☐ 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]: 30 days

## 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.

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

Affix Patient Label

**AUTHORIZATION FOR USE AND DISCLOSURE**

8700-1002
(Rev. 3/21)

White - Med Records Yellow - Patient

## ADDITIONAL RIGHTS AND REQUIREMENTS IF REQUESTOR SEEKS THIS AUTHORIZATION[3]

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 (pursuant to HIPAA laws and regulations).
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. Please be aware that once your information leaves Tri-City Medical Center, Tri-City Medical Center will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.
6. Information disclosed pursuant to this Authorization could be re-disclosed by the recipient and might no longer be protected by the federal confidentiality law (HIPAA).
7. I hereby release Tri-City Medical Center and its employees and my attending physicians and their associates from any and all legal liability that may arise from the release of this information to the party named on Page 1 of this Authorization Form.

## 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[2]:

_____

Witness: _____

***Authorization for Use or Disclosure of Health Information – Footnote references***

[1] This form may not be used to release both psychotherapy notes and other types of health information [(*see 45 CFR § 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.

[2] 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 #:** _____ **Completed by:**_____

**Distribution:** ☐ **Mail** ☐ **Pick-up** ☐ **CD** ☐ **Other** **Signature** **Date**