AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____

Address:_____
STREET CITY STATE ZIP

Phone (_____)_____ Date of Birth_____MR#_____

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.

REQUESTING RECORDS FROM:		WHERE TO SEND THE RECORDS TO:	
Name/Facility:		Name/Facility:	
Address:		Address:	
City: State: Zip:		City: State: Zip:	
Phone ( )	Fax ( )	Phone ( )	Fax ( )
		☐ Check box if you prefer a CD.	

Please send records from the following date range: From:_____ To:_____

☐ Labs ☐ History & Physical ☐ Radiology
☐ Progress Notes ☐ Immunization Record ☐ Other:_____

Purpose of requested use or disclosure: ☐ Transfer of Care ☐ Patient Request
☐ Insurance ☐ Legal ☐ Continuing Care ☐ Other:_____

I specifically authorize release of the following information (Check and initial as appropriate):

☐ Mental Health treatment information Initials:_____ ☐ HIV Information Initials:_____
☐ Alcohol/Drug Treatment information Initials:_____
*If not checked and initialed, the records containing such information can **NOT** be released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this autthorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

This authorization will automatically expire six months from the date signed, unless otherwise indicated. _____
Expiration date of Authorization

I understand that the requestor may not further use or disclose protected health care information unless another authorization is obtained, or unless law specifically requires disclosure.

The law permits the use or disclosure of protected health care information without authorization for the purpose of coordination a treatment plan, payment for services, and or to evaluate the quality of care you receive.

Patient Access to Records Fee: Pioneer Medical Group contracts with DataFile Technologies to copy and provide all medical records requested from our office. We receive the right to charge the fee schedule as set by California (CFR 164.524.) *You will be invoiced from DataFile Technologies, LLC for"Transfer of Care" and "Personal Copies" of your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records. In the case of continuity of care, we may transfer a minimal portion of your records directly to a physician as a courtesy.* _____
Initials

Signature of Patient or Legal Representative_____ **Date**_____

If not patient, state relationship_____

Signature of Witness_____