Rancho Paseo Medical Group

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.

First Name: _____ Mid. Initial _____ Last Name _____

Date of Birth: _____ Social Sec #: _____ Phone: _____

Address: _____ City _____ ST _____ Zip _____

I hereby authorize: _____

Address: _____ City _____ ST _____ Zip _____

Phone: _____ Fax: _____

to release to: Rancho Paseo Medical Group, 264 N. Highland Springs Ave. 5A, Banning, CA 92220
Ph: 951-769-0079, Fax: 951-845-6750

the following information:

a. ( ) All health information pertaining to my medical history, mental or physical condition – OR
( ) Only the following records or types of health information. Include date(s) of treatment:

_____

b. I specifically authorize release of the following information (check as appropriate):
( ) Mental health treatment information ( ) HIV test results ( ) Alcohol/drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

Purpose of requested use or disclosure: Patient request ( ); OR ( ) other:

_____

Expiration date: _____ (This authorization will expire in 6 months unless otherwise indicated).

- I may refuse to sign this authorization. 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 following address:
  Rancho Paseo Medical Group, 264 N. Highland Springs Ave. 5A, Banning, CA 92220
- 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 and will receive a copy of this authorization.
- 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).
  If this is checked (), the requestor will receive compensation for the use or disclosure of my information.

Signature: _____ Print: _____
(Patient/representative/spouse/financially responsible party)

Signature: _____ Print: _____
If signed by someone other than the patient, state your legal relationship to the patient:

Witness: _____ Date: _____