

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. I authorize **Desert Family Medical Center** to furnish health information as described below on (name of Pt.) _____

2. This authorization is limited to the following type and amount of information: (use dates where appropriate)

- All medical information for the last 2 years Immunization record
 Medication list Other _____
 Laboratory results from (date) _____ to (date) _____
 X-ray and imaging reports from (date) _____ to (date) _____
 All medical records relating to injury: (date) _____

3. ***I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about treatment for alcohol and drug abuse, and/or behavioral or mental health services.***

4. THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION: _____ Address: _____ _____
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5. The recipient may use the medical records and type of information authorized only for the following purposes:
 Patient access Continuation of care Application for ins. Other _____

6. 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 Services Department. I understand that the revocation will not apply to information that has already been released in response to the insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire in 60 days.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or request copies of the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information Services at the number listed below.

Signature of Patient or Legal Representative

Date

If signed by Legal Representative, Relationship to Patient

Signature of Witness

Recipients of outpatient psychotherapy records are required to destroy these records within 60 days unless they are incorporated into the patients medical records. It is the responsibility of the recipient to follow confidentiality policies and procedures for the maintenance and destruction of protected health information as set forth in A.B.416, 1999 Stat. ch. 527, adding Cal. Civil Code 56 et seq.

**Desert Family Medical Center
555 East Tachevah Drive Suite 2w-203
Palm Springs, Ca 92262
(760) 323-4272 – phone
(760)323-8597 – fax**

Patient Name: _____ Med. Rec #: _____ Date of Birth: _____ PCP: _____
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