



Authorization to Disclose Health Information from Desert Family Medical Center

This form allows Desert Family Medical Center to release the following listed patient's information to be disclosed to the indicated individual or organization.

Patient Name: _____ Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. Desert Family Medical Center is authorized to release and disclose the above named individual's health information.
3. The type and amount of information to be used or disclosed is as follows, include dates where appropriate is as follows:

Name of Report <i>(Check all that apply)</i>	Date of Service
<input type="checkbox"/> Entire Record	_____
<input type="checkbox"/> Abstract (Physician Reports, Test Results, Medication List)	_____
<input type="checkbox"/> Laboratory Results	_____
<input type="checkbox"/> X-Rays and Imaging Report	_____
<input type="checkbox"/> Physical Therapy Films	_____
<input type="checkbox"/> Other _____	_____

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

5. The information may be disclosed to and used by the following individual or organization:

Name of Individual or Organization: _____

Address: _____

Telephone: _____ Fax: _____

6. The recipient may use the medical records and type of information only for the following purposes:
 Patient Access Continuation of Care Application for Insurance Other _____

7. 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 director of this office. 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 insurers with the right to contest at 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 90 days.

8. 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 copy 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 any questions about disclosure of my health information, I can contact the health information management director of this office.

Signature of Patient or Legal Representative Date

If Signed by Legal Representative, Relationship to Patient Signature of Witness Date