COUNTY OF SAN DIEGO
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below.

DATE:	

PATIENT/RESIDENT/CLIENT

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:

TELEPHONE NUMBER:	SSN (OPTIONAL):	DATE OF BIRTH:

AKA's:

THE FOLLOWING IS AUTHORIZED TO MAKE THE DISCLOSURE.

NAME OR ENTITY:
MEDICAL RECORDS SERVICES

ADDRESS AND TELEPHONE NUMBER:
3851 ROSECRANS ST., SUITE 309 • SAN DIEGO, CA 92110 (619) 692-5700 X3

THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING.

NAME OR ENTITY:

ADDRESS AND TELEPHONE NUMBER:

TREATMENT DATES:	PURPOSE OF REQUEST: ☐ AT THE REQUEST OF THE INDIVIDUAL.

THE FOLLOWING INFORMATION IS TO BE DISCLOSED: (PLEASE CHECK)

- ☐ History and Physical Examination
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Medication Records
- ☐ Interpretation of images: x-rays, sonograms, etc.
- ☐ Laboratory results
- ☐ Dental records
- ☐ Psychiatric records including Consultations
- ☐ HIV/AIDS blood test results; any/all references to those results
- ☐ Physician Orders
- ☐ Pharmacy records
- ☐ Immunization Records
- ☐ Nursing Notes
- ☐ Billing records
- ☐ Drug/Alcohol Rehabilitation Records
- ☐ Complete Record
- ☐ Other *(Provide description)* _____

_____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Photocopy or Fax: I agree that a photocopy or fax of this authorization will be as effective as the original.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.

I have right to receive a copy of this authorization. I would like a copy of this authorization.
☐ Yes ☐ No

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE	
SIGNATURE:	DATE:
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:	

FOR OFFICE USE

VALIDATION	
SIGNATURE OF STAFF PERSON VALIDATING INFORMATION:	DATE:
SIGNATURE OF HEALTH CARE PROVIDER*:	DATE:

County of San Diego
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Client: _____
Record Number: _____
Program: _____