PALOMAR POMERADO HEALTH
A California Health Care District

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize

☐ **Palomar Medical Center**
555 E. Valley Pkwy.
Escondido, CA 92025
(760) 739-3280
FAX (760) 739-2670

☐ **Pomerado Hospital**
15615 Pomerado Road
Poway, CA 92064
(858) 613-4131
FAX (858) 613-4767

☐ **Escondido Surgery Center**
343 E. Second Avenue
Escondido, CA 92025
(760) 480-1288
FAX (760) 480-0756

☐ **PROS**
15708 Pomerado Rd.
Ste. N102
Poway, CA 92064
(858) 613-4636
FAX (858) 613-4248

☐ **Palomar Continuing Care Center**
1817 Avenida Del Diablo
Escondido, CA 92029
(760) 739-2000
FAX (760) 739-2109

☐ **Villa Pomerado**
15615 Pomerado Road
Poway, CA 92064
(858) 613-4545
FAX (858) 613-4766

☐ **Palomar Pomerado Home Care**
1540 E. Valley Pkwy., Suite 200
Escondido, CA 92027
(760) 796-6800
FAX (760)796-6897

☐ **Palomar Mental Health Unit**
555 E. Valley Parkway
Escondido, CA 92025
(760) 739-3240
FAX (760) 739-3233

☐ **Palomar Psychiatric Outpatient Program**
1540 E. Valley Pkwy., 1st Floor
Escondido, CA 92027
(760) 739-2971
FAX (760) 735-9067

☐ **Pomerado Psychiatric Outpatient Program**
15615 Pomerado Road
Poway, CA 92064
(858) 613-5613
FAX (858) 613-5624

☐ **Pomerado Hospital Behavioral Medicine Ctr.**
15615 Pomerado Road
Poway, CA 92064
(858) 613-5640
FAX (858) 613-5646

☐ _____
_____
_____
_____
(Name of Physician, Hospital or Health Care Provider)

to release information from my hospital records, including psychiatric, alcohol abuse, drug abuse (which may include 42 CFR Part 2 covered records) and acquired immunodeficiency syndrome (AIDS) records, and/or tests for or infection with human immunodeficiency virus (HIV) **TO:**

_____
Name

_____
Street Address Suite #

_____
City State Zip Code

This authorization is limited to the following medical records and type of information (**Check one**):

☐ Entire Record (**a per page charge applies**) ☐ ER Report _____
(From Date of Service)

☐ Medical Information Packet may include Discharge Summary, History & Physical, Consultations, Operative Reports, Lab Work, X-ray Reports, Diagnostic Reports, Pathology Reports.

☐ Biopsychosocial, E.D. Behavioral Health Assessment, 5150, 5250, Conservatorship Investigation, E.D. Physician Report, Medication Record, Nursing/M.D. Progress Notes

☐ Other _____

(From Date of Service)

The requestor may use the medical records and type of information authorized only for the following purposes:

☐ Continuing Medical Care ☐ Inspection of Record Only ☐ Insurance Claim

☐ Legal Matter ☐ Personal Copy ☐ Verbal Exchange ☐ Other

This authorization shall become effective immediately and shall remain in effect until

☐ 3 months from the date of this authorization or _____.

(Date)

NOTICE OF RIGHTS AND OTHER INFORMATION

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: _____

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

I understand that I have a right to receive a copy of this authorization form upon my request.

Copy requested and received:

☐ Yes ☐ No

I hereby release my attending physicians and their associates, and the hospital and its employees and agents from any liability from the release of this information.

I agree that a photocopy or faxed copy of this authorization shall be as valid as the original

Date: _____ Signature: _____

(Patient/Legal Representative)

Patient's Printed Name: _____ Patient's Birthdate: _____

If signed by other than Patient, indicate relationship to the patient: _____

Patient's Phone # _____