Authorization for Use & Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of health information about you.

patient name: ____ date of birth: ____/____/_ ____
address: ____
phone: (_____) _____-_______ SSN: _____-___-_______

I hereby authorize Rancho Paseo Medical Group
264 N. Highland Springs Ave., Suite 4
Banning CA 92220
Ph: (951) 769-0079 Fax: (888) 854-7592

□ Theodore Wyman, MD
□ Candice Lee-Wang, MD
□ Carol Remigio, NP
□ Frederick Lloyd, MD
□ Alan Valenzuela, PA
□ Patrick Black, PT

□ to **REQUEST** my health information from □ to **RELEASE** my health information to

name of PCP/clinic: ____
address: ____
phone: (_____) _____-_______ fax: (_____) _____-_______

This request and authorization applies to:

□ ALL my health information pertaining to my medical history, mental and/or physical condition

OR

□ Only the following records or types of health information: *(Please include dates of treatment.)*

____

I specifically authorize release of the following information: *(Please check all applicable boxes.)*

□ mental-health treatment □ HIV test results □ alcohol-/drug-treatment information

Purpose of requested use or disclosure: □ patient request □ continuity of care
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 the use or disclosure of which I am being asked to allow.
- 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., Suite 4, 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 the right to and will receive a copy of this authorization.
- Informed disclosure pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and federal confidentiality law (HIPAA).

____
Patient's name
(Please print.)

____
Responsible Party's name
(if different from Patient's name)
(Please print.)

____
Patient's and/or Responsible Party's signature

______/______/______
date

If signed by someone other than the patient, please select your legal relationship to the patient:
□ Parent □ Guardian □ Spouse □ Representative □ Financially Responsible Party