Providence
Mission Heritage
Medical Group

(OUTGOING RECORDS)

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you.
Failure to provide all information requested may invalidate this Authorization.

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Name of Patient: _____

A.K.A. (if any other name was used) _____

Date of Birth: _____ **SS #:** _____ **Phone:** _____

WHERE TO SEND YOUR RECORDS?

I hereby authorize **Mission Heritage Medical Group** to release my Medical Record to:

Name/Facility: _____ **Attention:** _____
Address: _____ **Phone:** _____
City: _____ **State:** _____ **Zip:** _____ **FAX:** _____

Records will be mailed to the above address. There are fees associated with copying and mailing of medical records.

☐ Normally we send paper copies; check box if you would like a CD instead.

WHAT RECORDS TO SEND?

Please send records from the following date range: from _____ to _____

***If no dates are entered only the last 2 years will be released**

Please send the following types of records:

☐ Specific Doctor(s) Only _____ ☐ Labs
☐ Progress Notes ☐ Radiology Reports
☐ Other: _____

AUTHORIZATION TO RELEASE STATUTORILY PROTECTED INFORMATION:

I specifically authorize release of the following information (check and initial as appropriate):

☐ Mental health treatment information Initial if requesting: _____
☐ HIV test results Initial if requesting: _____
☐ Alcohol/drug treatment information Initial if requesting: _____

*If not checked and initialed, the records containing such information can **NOT** be released.

WHAT IS THE PURPOSE OF REQUESTING THESE RECORDS?

☐ Continuing Care ☐ Patient Request ☐ Legal
☐ Insurance ☐ Other _____

***If no box is checked; this will be treated as a continued care request.**

26732 Crown Valley Pkwy, Suite 441 Mission Viejo, CA 92691
Phone: (949) 282-1675 Fax: (949) 276-3689

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WHEN WILL THIS REQUEST EXPIRE?

This Authorization expires [insert date]: _____

***If no Date is given; this authorization will expire 6 months from the signature date.**

WHAT ARE MY RIGHTS?

- I may refuse to sign this Authorization. If I refuse to sign this Authorization, I should know that by law, my health information cannot be released. 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 that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: **Mission Heritage Medical Group**
  Medical Records
  26732 Crown Valley Pkwy., Suite 441
  Mission Viejo, CA 92691
- My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.
- I have a right to receive a copy of this Authorization. Copy requested and received:
  ☐ **Yes** ☐ **No** **Initial**_____ **Date:** _____
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).
- A photocopy or facsimile of the authorization is as valid as the original.

SIGNATURES:

Patient Signature: _____ **Date:** _____

THIS SECTION MUST BE FILLED OUT IF THE PATIENT DID NOT SIGN ABOVE:

Legal Representative Signature: _____ **Date:** _____
State your legal relationship to the patient and why you have the authority to act for the patient:_____

(The legal representative must submit proof of legal representation)
Witness Signature: _____ **Date:** _____

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