# Authorization for Use or Disclosure of Protected Health Information

North Coast Family Medical Group, Inc.
477 N. El Camino Real, Suite A306, Encinitas, CA 92024
(760) 942-0118 Phone (760) 942-5319 Fax

As required by the Health Information Portability and Accountability Act ("HIPAA") of 1996 and California law, North Coast Family Medical Group, Inc. may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving your permission for the uses and disclosure described below. Please be aware that once your information leaves North Coast Family Medical Group, Inc., we will no longer be able to protect that information and the recipients of your information may not be legally required to protect your information. I hereby release North Coast Family Medical Group, Inc. from any and all legal liabilities that may arise from the release of this information to the party listed below. 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.

**I hereby authorize North Coast Family Medical Group, Inc. to disclose health information concerning:**

_____ _____
Patient's Name Date of Birth

**Transfer of Information from:**

North Coast Family Medical Group
477 N. El Camino Real Ste. A306
Encinitas, CA 92024

**Information May be released to:**

Physician/Facility Name, Address, phone/fax:
_____
_____
_____

**Health Information to be used or disclosed (check appropriate box(es):**

☐ **Pertinent Information (This is what most physicians need): Problem list, last 2 years of Progress notes, immunizations, labs, radiology, diagnostic testing**
☐Only dates of service from _____ to _____
☐Entire Medical Record , including Web Portal Communication
☐Other (please specify):_____

**Authorization to Release Statutorily Protected Information**

**I specifically authorize release of the following information (Initial if authorized)**

Provider Name/Signature:

_____ Psychiatric Progress Notes _____
_____ Therapy Notes _____
_____ Mental Health Labs _____
_____ HIV test results _____
_____ Alcohol/drug treatment information _____

For patients requesting medical records, there will be a fee of $15.00 per request and .25 for each additional page.

_____ _____

Patient's Name Date of Birth

**Purpose of requested use or disclosure:**

☐Continuing Care ☐Inspection of Record ☐Legal Matter
☐Insurance Claim ☐Personal Copy ☐Second Opinion
☐Other (please specify): _____

**Expiration**

This authorization expires (date) _____. If no date is given, this authorization will expire 6 months from the signature date.

**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:

**North Coast Family Medical Group**
**477 North El Camino Real, Suite A306**
**Encinitas, CA 92024**

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).

**Signed:** _____ **Date:**_____

**Print Name:**_____ **Telephone:**_____

If not signed by the patient, please indicate relationship:

☐ **Parent or guardian of minor patient –**

I here by declare under penalty of perjury, that I am the natural or adoptive parent or legal guardian of said child and there is no court order restricting or prohibiting my access to such medical records.

☐ **Guardian or conservator of an incompetent patient or representative of deceased patient**

**Witness, Print Name:** _____ **Date:**_____

**Witness Signature:**_____

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