Yucca Family Medical Care

57675 29 Palms Hwy. Ste. #111 Yucca Valley, CA 92284

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I authorize _____

. (name of physician of healthcare provider to use or disclose information)

To furnish to _____ Yucca Family Medical Care Fax # 760-365-8599_____

(Name and address of person/organization to which disclosure is made)

Health information described below on:_____

(Patient Name)

For the purpose of: _____

This information is limited to the following type and amount of information. (Use dates where appropriate).

__ Progress Notes
__ Consultation Reports
__ Laboratory/Pathology Reports
__ Radiology/Imaging Reports
__ Medical Records relating to injury
__ Immunization Records

Specific Date From_____ to_____
__Other_____
_____

__ Any and all records for last 2years

DISCLOSURE REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release at any time. I understand that my revocation must be in writing and presented to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization will expire on the following dates event or condition:

_____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on providing or refusing this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Director of Health Information. I understand I have a right to receive a copy of this authorization.

_____
Signature of Patient, Parent or Legal guardian

_____
Patient Date of Birth

_____
If signed by other than patient, indicate authority to sign

_____
Patient Address

_____
Patient telephone number

_____
Patient Social Security Number

_____
Witness signature

_____
Date