HURTT familyhealth CLINIC

One Hope Dr Tustin, CA. 92782
Clinic: (714) 247-0300 Fax: (714) 259-1598
www.rescuemission.org

Providing highly accessible, preventative, primary and specialized healthcare to homeless and underserved families

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Note to Client: A FEE MAY APPLY TO THIS REQUEST FOR RECORDS.

CLIENT (PATIENT) INFORMATION

Name _____ _____ _____ **Telephone: (_____)** _____
LAST *FIRST* *MI*

Address _____
STREET ADDRESS *CITY* *STATE* *ZIP CODE*

SSN_____ **Date of Birth** _____ **Patient Record Number** _____

The undersigned hereby authorizes the disclosure of the Protected Health Information (PHI) of the above named individual:

Disclose PHI from:	**Disclose PHI to:**
	Hurtt Family Health Clinic **One Hope Drive** **Tustin, CA. 92782** **Clinic: (714) 247-0300 Fax: (714) 259-1598**

An authorization to disclose PHI is voluntary. Treatment, payment or eligibility for benefits will not be affected if you do not sign this authorization. Redisclosure of a person's PHI is prohibited without the specific written authorization of that person or as otherwise permitted by state or federal law. Information disclosed pursuant to this authorization may be disclosed by the recipient and no longer be protected by California or federal law.

PHI TO BE DISCLOSED: (Please check all applicable categories)

- ☐ **Complete Copy of Medical Records**
- ☐ **X-Ray Reports/Films**
- ☐ **Dental Records**
- ☐ **Alcohol Treatment/Evaluation**
- ☐ **HIV Test Results**
- ☐ **Lab Reports**
- ☐ **Allergy Records**
- ☐ **Mental Health Records**
- ☐ **Drug Treatment/Evaluation**
- ☐ **AIDS/AIDS-Related Illness**
- ☐ **Immunization Records**
- ☐ **Physical Exams**
- ☐ **Developmental Disabilities**
- ☐ **Other (please specify):** _____

PURPOSE OF DISCLOSURE OF PHI:

_____

(e.g., the request of the individual, continuity of care, attorney access, court case, insurance, disability, etc.)

This authorization will remain in effect until the request is processed unless otherwise specified below. This request may be revoked at any time by sending a written request to the custodian of records.

☐ Expires as specified:_____ (Authorization includes future records generated until expiration)

I hereby authorize the release of the PHI of the above named individual in accordance with the specifications listed above. I understand that I have a right to receive a copy of the disclosed material.
A photocopy/fax of this consent shall be valid as the original.

Signature: _____ **Date:** _____

Printed Name: _____ **Relationship to above named individual:** _____