HURTT familyhealth CLINIC

Account Number: _____

Authorization to use and disclose Protected Health Information (PHI)

Note to Client: A fee may apply to this request for records.

Patient Information				
Last Name	**First Name**		**MI**	**Date of Birth**
Address **Apt./Unit**	**City**		**State**	**Zip Code**
SSN	**Email Address**			
Please check primary phone	☐ **Home Phone** ( )	☐ **Cell Phone** ( )	☐ **Work Phone** ( )	

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

Disclose PHI from:

Hurtt Family Health Clinic

☐ Tustin –VOH
1 Hope Drive,
Tustin, CA 92782

☐ Tustin–2
14642 Newport Ave.
STE 200
Tustin, CA 92780

☐ Santa Ana
1100-B North Tustin Ave.,
STE A
Santa Ana, CA 92705

☐ Anaheim
947 S. Anaheim Blvd.,
STE 260
Anaheim, CA 92805

Clinic: (714) 247-0300 Fax: (714) 259-1598
Medical.Records@hurttclinic.org

Disclose PHI to:

An authorization to disclose PHI is voluntary. Treatment, payment or eligibility for benefits will not be affected if you do not sign this authorization. Re-disclosure 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	☐ Lab Reports	☐ Immunization Records
☐ X-Ray Reports/Films	☐ Allergy Records	☐ Physical Exams
☐ Dental Records	☐ Mental Health Records	☐ Developmental Disabilities
☐ Alcohol Treatment/Evaluation	☐ Drug Treatment/Evaluation	☐ Billing Statements
☐ HIV Test Result	☐ AIDS/AIDS- Related illness	☐ ER Discharge & Consult Notes (if available)

☐ 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 six months from date 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:	Relationship to patient, if not patient:	Date: