



AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

All sections must be completed for the authorization to be valid.

Use "N/A" if not applicable

Form: Page 1 of 2

PATIENT INFORMATION						
Last Name	First Name	MI Date of Birth				
Address	Apt./Unit	City		State	Zip Code	
SSN	Email Address				1	
Please check primary phone ()		□ Cell Phone ()	□ Work Phone ()			
INDIVIDUAL/ORGANIZATION AUTHORIZED TO RELEASE PHI						
INDIVIDUAL/ORGANIZATION AUTHORIZED BY SIGNATORY TO RECEIVE PHI						
Hurtt Family Health Clinic: (71 Clinic	4) 247-0300 Fax: (714)	259-1598				
	-On Newport Ave.	🗆 Santa Ana	🗆 Santa Ana			
	wport Ave.	1100-B North Tustin Ave., STE A 947 S. Anaheim Blvd.,				
Tustin, CA 92782 STE 200 T	ustin, CA 92780	Santa Ana, CA 92705		STE 260 Anaheim, CA 92805		
HEALTH RECORDS TO BE RELEASED - GENERAL (PLEASE CHECK ALL APPLICABLE CATEGORIES)						
□ Complete Copy of Medical □ Lab Reports □ Physical Exams						
Records					: Notes (if	
Dental Records Immunization Records available)						
C X-Ray Reports/Films						
Other (please specify):						
HEALTH RECORDS TO BE RELEASED - SPECIFIC						
□ Communicable Diseases Signature:				Date:		
Genetic Testing	Signature:			Date:		
HIV Test Result	Signature:			Date:		
Medication Treatment	Signature:			Date:		
Mental Health	Signature:			Date:		
Substance Use Disorder	Signature:			Date:		
Requests for psychotherapy notes require a separate authorization and may not be combined with any other request						
for health records.						
Psychotherapy Notes	Signature:			Date:		



Account Number:

All sections must be completed for the authorization to be valid.

Use "N/A" if not applicable

Form: Page 2 of 2

Health Care Personal Legal Other (please specify): AUTHORIZATION INFORMATION Iunderstand the following: I authorize the use or disclosure of the health information as described above for the purpose listed. I understand this authorization is voluntary. I have the right to revoke this authorization. To do so I understand I must submit my revocation in writing to the party entered in Part II. The revocation will prevent further release of my health information from the date of receipt. I am signing this authorization voluntarily and understand my health care treatment will not be affected if I do not sign this authorization or as specifically permitted by Cal. Code §56.10 or required by law (applies within California only). If the party entered in Part III is not a HIPAA Covered Entity or Business Associate as defined in 45 CFR §160.103, the released health information my no longer be protected by federal and state privacy regulations. I have a right to receive a copy of this authorization. Fees may be charged to cover the cost of releasing the health information. I understand that my substance abuse disorder records are protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be redisclosed without my written authorization. Signature: Date:	PURPOSE OF DISCLOSURE OF PHI			
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Signature: Date: Name of person signing form if not patient:	SIGNATURE BY OR ON BEHALF OF PATIENT			
Signature: Date: Name of person signing form if not patient:	Name of Patient (Print):			
Authority to sign on behalf of patient:				
Name of translator (if applicable):	Name of person signing form if not patient:			
Signature of translator (if applicable): 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.	Authority to sign on behalf of patient:			
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