

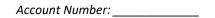


MEDICAL REALEASE FORM AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

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		МІ	Date of Birth		
Address		Apt./Unit	City	•	State	Zip Code	
SSN		Email Address				1	
Please check primary phone		one	☐ Cell Phone ☐ V		/ork Phone)		
INDIVIDUAL/ORGANIZATION AUTHORIZED TO RELEASE PHI							
Hurtt Family Health Clinic 14642 Newport Ave. STE 200 Tustin, CA 92780 Phone: (714) 247-0300 Fax: (714) 259-1598							
INDIVIDUAL/ORGANIZATION AUTHORIZED BY SIGNATORY TO RECEIVE PHI							
HEALTH RECORDS TO BE RELEASED - GENERAL (PLEASE CHECK ALL APPLICABLE CATEGORIES)							
	Complete Copy of Medical Records Dental Records X-Ray Reports/Films Other (please specify):	□ Lab Reports□ Allergy Reco□ Immunizatio	rds \square ER Dis			Notes (if	
HEALTH RECORDS TO BE RELEASED - SPECIFIC							
	Communicable Diseases S	ignature:			Date:		
	Genetic Testing S	ignature:			Date:		
	HIV Test Result S	ignature:			Date:		
	Medication Treatment S	ignature:			Date:		
	Mental Health S	ignature:			Date:		
☐ Substance Use Disorder S		Signature:			Date:		
Requests for psychotherapy notes require a separate authorization and may not be combined with any other request for health records.							
	Psychotherapy Notes S	ignature:			Date:		





MEDICAL REALEASE FORM

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 2 of 2

PURPOSE OF DISCLOSURE OF PHI						
☐ Health Care ☐ Personal ☐ Legal ☐ Other (please specify):						
AUTHORIZATION INFORMATION						
I understand 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. The party entered in Part III is prohibited from re-disclosing the health information except with a written 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 may 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 BY OR ON BEHALF OF PATIENT						
Name of Patient (Print):						
Signature: Date:						
Name of person signing form if not patient:						
Authority to sign on behalf of patient:						
Name of translator (if applicable):						
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. Expires six months from date specified:/						

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