HURTT familyhealth CLINIC

Account Number: _____

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

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** ( )	

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 Records
- ☐ Immunization Records
- ☐ Physical Exams
- ☐ ER Discharge & Consult Notes (if available)

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:

HURTT familyhealth CLINIC

Account Number: _____

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

PURPOSE OF DISCLOSURE OF PHI

☐ Health Care ☐ Personal ☐ Legal ☐ Other (please specify):

AUTHORIZATION INFORMATION

I understand the following:

1. I authorize the use or disclosure of the health information as described above for the purpose listed. I understand this authorization is voluntary.
2. 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.
3. I am signing this authorization voluntarily and understand my health care treatment will not be affected if I do not sign this authorization.
4. 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).
5. 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.
6. I have a right to receive a copy of this authorization.
7. Fees may be charged to cover the cost of releasing the health information.
8. 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: _____/_____/_____