Genesee Medical Group

Authorization to Release Protected Healthcare Information

Name of Patient _____ Street Address _____

Phone Number _____ Fax Number _____ City _____ State _____ Zip Code _____

Email Address (please be sure to print clearly) _____ Date of Birth (00/00/0000) _____ Last Four Digits of SSN _____

I hereby give the following entity permission to release my Protected Health Information (PHI):

Genesee Medical Group 7830 Clairemont Mesa Blvd., Suite 100 San Diego, CA 92111
Ph. (858) 268-1111 (Medical Records x 301 Privacy Officer x311) Fax (858) 268-0761

I instruct the above named entity to produce the following information: (Check ONE only)

____ Release a 2 year abstract of my records ____ Entire Record (subject to state regulated rates)

____ I would like specific records released: _____

I authorize the above listed records to be released to the following entity:_____

_____

You must complete the full name and address of where you want your records released.

This authorization expires ninety (90) days from signature, or at the following event: _____

I am requesting my PHI to be disclosed for the following purpose: _____

HIV, Behavioral Health, or Drug and Alcohol Abuse/Treatment information contained within the dates of service I have specified above *are to be released through this authorization* unless specified below:

DO NOT RELEASE: (Check all that apply) ___ HIV ___Behavioral Health ___ Drug/Alcohol

I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian or Personal Representative (attach proper documentation) Date

Your State Legislature determines the cost of records. Any payments are required prior to release.