Sun City Medical Partners

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: _____ Re: _____

_____ DOB: _____

_____ Date: _____

I authorize the use or disclosure of my health information as described below. The above-listed individual or organization is authorized to make the disclosure.

The type and amount of information to be used or disclosed is as follows:

_____ Problem list
_____ Medication list
_____ List of allergies
_____ Emergency room records
_____ Immunization record
_____ All history and physical information
_____ Entire record
_____ PCP notes last 1 year
Specialist notes last 1 year
Lab results last 1 year
Radiology reports last 3 years

_____ Laboratory results from _____ to _____
_____ X-ray and imaging reports from _____ to _____
_____ Consultation reports from _____ to _____
_____ Drug and alcohol treatment
_____ Psychotherapy records/mental health records
_____ All discharge summaries and admission records
_____ Other _____

*****PLEASE MAIL RECORD TO OUR OFFICE*****

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV). It may also include information above behavioral or mental services, and treatment for alcohol or drug abuse.

This information may be disclosed to and used by the following individual or organization:
Name: **SUN CITY MEDICAL PARTNERS ATTN: DR. NGUYEN**
Address: **27830 BRADLEY ROAD, SUN CITY CA 92586**
For the purpose of: _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provided my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

I understand that the entity or person releasing records will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. I understand that the information used or disclosed as a result of this Authorization may be subject to re-disclosure by the person or entity receiving such information, and thus no longer protected by the federal privacy regulations.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provide in CFR 164-524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my HIM director or privacy officer.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness