

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. I authorize **Desert Oasis Healthcare** to furnish health information as described below on (name of patient): _____

2. *This authorization is limited to the following type and amount of information:*

(Use dates where appropriate)

- Medical Record for past two years
- Medication List
- Laboratory results from (date) _____ to (date) _____
- X-ray and imaging reports from (date) _____ to (date) _____
- All medical records relating to injury: (date) _____
- Immunization Record
- Other _____

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

4. THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:

Address: _____

5. The recipient may use the medical records and type of information authorized only for the following purposes:

- Patient access
- Continuation of care
- Application for insurance
- Other _____

6. I understand that I have a 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 Services Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides 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: (indicate expiration date)_____. If I fail to specify an expiration date, event or condition, this authorization will expire in 2 years.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION – (Cont.)

7. 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 that I may inspect or request copies of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information Services at the number listed below.

Signature of Patient or Legal Representative

Date

If Signed by Legal Representative, Relationship to Patient

Signature of Witness

Recipients of outpatient psychotherapy records are required to destroy these records within 60 days unless they are incorporated into the patient's medical record. It is the responsibility of the recipient to follow confidentiality policies and procedures for the maintenance and destruction of protected health information as set forth in A.B.416, 1999 Stat.ch.527, adding Cal. Civil Code 56 et seq.



Your Health. Your Life. Our Passion.

275 N. El Cielo Road, Palm Springs, CA 92262

Phone (760) 320-8814, Ext. 1072, Fax (760) 969-5942

Patient Name: _____
Med. Rec. #: _____
Date of Birth: _____
PCP: _____