AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(Request for Outside Records to be Sent to DOHC)

IMPORTANT: ALL SECTIONS MUST BE COMPLETED FOR FORM TO BE VALID

1. RECORD REQUESTED **FROM**: ____

____

Address: ____

____

Phone: ______________________________ Fax: ________________________

2. I authorize the individual or organization indicated above to furnish health information as described below on (Name of Patient): ____________________________
Date of Birth: ___________________________

3. ***This authorization is limited to the following type and amount of information:*** (use dates where appropriate)

- ❑ Medical Records for the last 2 years
- ❑ Immunization Record
- ❑ Medication List
- ❑ Other ________________________
- ❑ Laboratory results from (date) __________________ to (date) ___________________
- ❑ X-ray and imaging reports from (date) __________________ to (date) ____________
- ❑ All medical records relating to injury: (date) __________________________________

4. 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.

5. PLEASE SEND THIS INFORMATION TO:

Provider: ________________________________

Attn: CORRESPONDENCE COORDINATOR
DESERT OASIS HEALTHCARE
275 N. EL CIELO ROAD, SUITE C
PALM SPRINGS, CA 92262

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

6. 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 ____________________

7. 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: ____________________________________. If I fail to specify an expiration date, event or condition, this authorization will expire in 60 days.

8. 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 Manager of Health Information Services at (760) 320-8814, Ext. 1076.

____________________________________ __________ ____________________

Signature of Patient, Parent, or Legal Representative Date

____ ____________________

If Signed by Legal Representative, Relationship to Patient Signature of Witness
(Only if signed by Legal Representative)

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.