AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

SADDLEBACK MEDICAL GROUP

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I, the undersigned, hereby authorize Saddleback Medical Group, Inc. to release and disclose a copy of my **Protected Health Information (Medical Records)** to the person/organization specified below**:**

Release Medical Records FROM:	**Disclose Medical Records TO**: ☐ **Facility** ☐ **Patient**
Name of Facility Producing Records	Name of Facility/ Patient Receiving Records
Street Address / Mailing Address	Street Address / Mailing Address
City, State, Zip	City, State, Zip
Phone Fax	Phone Fax

An authorization to disclose Protected Health Information (PHI) is voluntary. Treatment, payment, or eligibility for benefits will not be affected if you do not sign this authorization. Redisclosure of a person's PHI is prohibited without the specific written authorization of that person or as otherwise permitted by state or federal law. Information disclosure pursuant to this authorization may be disclosed by the recipient and no longer be protected by California or federal law.

Information to be disclosed: (Please check all that apply and identify clinic and time period as necessary.)

☐ **Pertinent Medical Records** (Progress Notes, History & Physical, Consultation, Laboratory, and X-ray.)
☐ **Mental Health PHI / Psychotherapy Notes** (Date of Service) _____ **Patient Initials** _____
☐ **Alcohol/Substance Abuse Treatment PHI** (Date of Service) _____ **Patient Initials** _____
☐ Urine Test ☐ Progress in Treatment ☐ Other: _____
☐ **HIV Results / AIDS Treatment PHI** (Date of Service) _____**Patient Initials** _____
☐ **Billing Records** (Date of Service) _____ ☐ **Specific Medical Records** (Date of Service) _____
☐ **Authorization for Inspection of Medical Records** **Patient Initials** _____
☐ **The information to be released from my medical records shall be limited to: _____**

The reason for requesting that my medical records be copied is:

☐ Changed Insurance ☐ Second Opinion ☐ Personal Use
☐ Changed Doctor ☐ Unhappy with Care/Service ☐ Legal Case
☐ Moving Out of Area ☐ Accident/Third Party Liability ☐ Other _____

UNLESS OTHERWISE REVOKED IN WRITING, THIS AUTHORIZATION EXPIRES ON:

☐ Completion of this request (one-time disclosure) ☐ Six months from signature date below
☐ Expires as specified: _____

There is a charge for copying your medical records and transferring them to another physician outside of Saddleback Medical Group. *The charge starts @ $25.00 plus postage*. This charge covers clerical cost and materials used to produce the records. Our medical record personnel will assist you with the processing of your request. Picking up your medical records is by appointment only. Please allow at least 48 hours to process your request. ***I agree to pay this reasonable charge to cover the cost of clerical cost incurred in making the medical records available.***

Patient Name: _____ **Date of Birth**: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Email: _____ Date: _____
Signature: _____ Relationship to Patient: _____

*** Authorized representative must submit copies of legal documents supporting assignment of this authority, i.e. POWER OF ATTORNEY.** This authorization for use of disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56, et.se., California Civil Code. Effective January 1, 1983, California law guarantees patients access to their medical care and specifies available procedures. Health & Safety Code 1795 et. sec. declares that "every person having ultimate responsibility for decisions respecting his/her own health care also possesses a concomitant right of access to complete information respecting his/her condition and care provided." In compliance with California's Health & Safety Code 1795.12, it is our policy to allow current and former adult patients, parents of minor patients (with exceptions), patient guardians or conservators, and decreased patient's beneficiaries or personal representatives to inspect the patient's medical records within five working days after receiving a written request or to ensure that copies are transmitted within 15 days after receipt of the written request and payment of reasonable clerical costs.