HI-DESERT
FAMILY HEALTH CLINICS
HI-DESERT MEMORIAL HEALTH CARE DISTRICT

Hi-Desert Family Health Clinic - Yucca Valley
58375 29 Palms Highway, Suite B
Yucca Valley, CA 92284
Ph. (760) 365-9305 Fax (760) 365-9309

AUTHORIZATION FOR USE OF DISCLOSURE OF HEALTH INFORMATION OR PATIENT'S REQUEST FOR ACCESS TO OR COPY OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you.
Failure to provide *all* information requested may invalidate this authorization.

Name of Patient: _____ Date of Birth: _____
Last, First MI

Medical Record Number _____ Phone Number: _____

If you are requesting a copy of your records for your personal use, there may be fees associated with your request. California law (Health and Safety Code section 123110(b)) specifies a charge not exceeding $0.25 per page for copied medical records. Your cost for requesting a copy of your medical record is:

The first (15) pages: No charge
Pages 16 and above: $0.25 per page
Payment must be made at the time you receive the copies.

I hereby authorize: **Hi-Desert Family Health Clinics**

to release to: _____
Name Phone Number

_____
Address City State/Zip

Dates of Service: From (date) _____ to (date) _____

METHOD: ☐ Mail ☐ Patient Pick-Up ☐ Fax No. _____

This authorization is for full disclosure of all records, including:

☐ Healthcare received from (date)_____ to (date) _____
☐ Medical consultations provided by (Physician): _____
☐ Recent pertinent medical information only (last 12 months)
☐ Other (please specify): _____

☐ Recent laboratory test results (last 30 days)
☐ Recent X-Ray reports (last 30 days)
☐ Recent physician progress notes (last 30 days)
☐ Complete health record

If you are requesting access to records relating to any of the following, please initial each item to confirm your request. *(These classes of information are protected by special privacy laws and access may be subject to special rules or may be restricted under certain circumstances).*

_____ HIV/Aids test results (requires approval by your physician)
_____ Psychological care (requires written approval by your psychologist or social worker)
_____ records regarding alcohol or drug abuse treatment

A separate authorization is required to permit the disclosure or use of psychotherapy notes.

PURPOSE

The above information is released for the following purpose and that purpose only:

☐ Personal request ☐ Continuation of Care ☐ Legal Purposes
☐ Insurance purposes ☐ Employer/Military requirement

☐ Other: _____

EXPIRATION

This Authorization expires (date): _____

(over)

MY RIGHTS

Right to Revoke	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 submit it to the following address: Hi-Desert Family Health Clinic, 58375 29 Palms Hwy., Yucca Valley, CA 92284. My revocation will take effect upon receipt by Hi-Desert Medical Center. I understand that the revocation will not apply to information that has already been released based on this authorization.
Expiration	Unless otherwise revoked, this authorization will expire on listed date. If I do not specify an expiration date, event, or condition, this authorization will expire one (1) year from signature.
Redisclosure	Information disclosed pursuant to this authorization could be re-disclosed by the recipeint. Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by the federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
Other Rights	I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CRF 164.524. I have the right to receive a copy of this authorization. If I have any questions about disclosure of my health information, I can contact the Privacy Officer at (760) 366-6476.

All requests for copies of medical record or other proctected health information are processed in the order they are received. It may not be possible to provide to you the requested information at the time of your request. If we are not able to process your request immediately, please allow 7-10 business days to process of the request. We will contact you by phone when the requested information is available.

SIGNATURE

I have read and confirm the terms of access stated herein:

Signature of Patient or
Legal Representative: _____ Date: _____

If signed by someone other than the patient, indicate relationship: _____

Print Name: _____
(Legal Representative)

☐ *Patient/Representative identification verified by:* _____
(Staff member's name verifying ID & date)

FOR PHYSCOLOGICAL OR MENTAL HEALTH RECORDS

CAREGIVER'S APPROVAL TO RELEASE INFORMATION

The undersigned physician, psychologist or licensed clinical social worker who is in charge of the patient: _____ hereby (check one) ☐ approves; ☐ disapproves the release of information and records to the patient or legal guardian specified herein.

Note: If disclosure is disapproved, give reasons below, and note any restrictions to the release of information.

_____

_____

_____

_____ _____
Physician/Caregiver Signature Degree

_____ _____
Printed Name Date