Authorization to Release Medical Information

Note: Please allow up to 30 days for your records to be copied per HDC policy.

The attached medical information is protected under HIPPA regulations and is confidential and legally privileged and is pertaining to:

_____

Patient's Name *Birth Date*

High Desert Clinic has the authorization of the patient to provide records to, or receive records from the following clinic(s). Choose which clinic you would like the records from or sent to.

From: _____

To: _____

Address/Fax Number: _____

Reason for Request: _____

Medical Records to be released:

[ ] Visit notes **[ ] Labs/results** **[ ] X-Rays** **[ ] Correspondence** **[ ] All Records**

Dates of treatment: _____

These records are for the sole perusal of the above listed entity only. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is being sent. It may not be possible to ensure your right to the protection of the privacy of this information one HDC discloses it to another party.

In addition to the general authorization to release records, the undersigned further authorizes the individuals or entities listed above to provide a copy of the following records:

1) Records of treatment for drug or alcohol abuse or psychiatric illness **[ ] YES [ ] NO**

2) Records of testing diagnosis or treatment of HIV, HIV-related illness, AIDS, AIDS-related illness and communicable disease related information. **[ ] YES [ ] NO**

This authorization shall be considered invalid after 6 months (or 60 days with drug/alcohol abuse records) from date of signing. The undersigned may revoke this authorization at any time by providing written notice of revocation. However, the undersigned may not revoke the authorization retroactively for information already released.

With respect to any drug/alcohol abuse treatment information protected by federal confidentially rules and release pursuant to this authorization, or records regarding communicable disease related information, the recipient of this information understands that it is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the undersigned or otherwise permitted by applicable law.

_____

Signature: Patient OR legally authorized representative ***Today's date***

If GUARANTOR, type of guardianship:_____

_____

Signature: Witness ***Date***