Authorization for Use by or Disclosure of Health Information from Palomar Health and Arch Health Medical Group to Mayo Clinic Care Network

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

PATIENT INFORMATION	
*NAME (Last, First, M.I.)	MAIDEN OR OTHER NAME
*DATE OF BIRTH	PHONE

*Release To:

I, (the patient) _____ **(please print)** hereby authorize **Palomar Health and/or Arch Health Medical Group** to release information from or copies of my medical records to the Mayo Clinic Care Network.

- **The purpose of this release is:** For medical consultation with the medical staff of the Mayo Clinic.
- **Type of Health Information to Release:** Referral summary, hospitalization reports, ambulatory visit notes, lab test results, radiology reports, diagnostic test reports and images, or other medical information as deemed appropriate for the consultation.

Expiration of Authorization

This authorization becomes effective upon signing and will expire upon my written revocation. _____ **(Initial)**

Patient Rights

I, the patient or the patient's legal representative, understand that:

- I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered or mailed to:

  Arch Health Medical Group
  15611 Pomerado Road
  Poway, CA 92064

  If I revoke this authorization, the revocation will not have any effect on actions taken prior to Arch Health Medical Group receiving the revocation.

- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal privacy 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.
- I have a right to a copy of this Authorization.

*
_____ _____

Signature of Patient or Patient's Legal Representative Date

*
_____

(If legal representative, state relationship to patient)

***Required for valid Authorization**