

# Authorization for Use or Disclosure of Health Info From Arch Health Medical Group



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, \_\_\_\_\_ (please print) hereby authorize **Arch Health Medical Group** to release information from or copies of my medical records to:

MYSELF	PHYSICIAN OR OTHER PARTY	
<input type="checkbox"/> I will pick up the records <input type="checkbox"/> Email to: _____ <input type="checkbox"/> Mail to address on record <input type="checkbox"/> Fax to: _____	*NAME (Last, First, M.I.) <hr/> STREET CITY <hr/> STATE, ZIP CODE PHONE <hr/> FAX	

**\*TYPE OF HEALTH INFORMATION TO RELEASE: CHECK THE BOX(ES) THAT APPLY:**

Pertinent Reports for transferring doctors  
 All medical records available. *Fee applies.* (Not to be used for transferring doctors/referrals)  
 All for specific medical condition: \_\_\_\_\_  
 Substance abuse       Immunization record       Psychiatric       Mammograms  
 X-ray Reports of: \_\_\_\_\_  
 History and physical exam       X-ray film (Fee applies)       Progress notes       HIV test results  
 Lab Test       Specific date of service

**\*THE PURPOSE OF THIS RELEASE IS:**

Continuing medical care       Insurance       Legal matter  
 At my request (*fee may apply*)       School       Other: \_\_\_\_\_  
 Specify limitations (if any) on the use of the information: \_\_\_\_\_

**Expiration of Authorization**

This Authorization becomes effective upon signing and will expire **one year from date of signature**, unless specific expiration date is given: (date) \_\_\_\_\_

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## 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)

\_\_\_\_\_  
Action completed by

\_\_\_\_\_  
PHI log completed

**\*Required for valid Authorization**