Authorization for Use or Disclosure of Health Information from Arch Health Medical Group to Designated Persons

Completion of this document authorizes the disclosure and use 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

I, _____(patient) (please print) hereby authorize **Arch Health Medical Group** to release **any and all** information about my *health, medical condition* or *billing for services* to members of family or other persons, as specified below. This includes verbal discussions with the medical/nursing staff and copies of my medical record.

DESIGNATED PERSONS	
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE

***THE PURPOSE OF THIS RELEASE IS**

☐ At my request ☐ Continuing medical care ☐ Other _____

Specify limitations (if any) on the use of the information: _____

_____

_____

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*Expiration of Authorization

This authorization becomes effective upon signing and will expire upon my written revocation.

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 Partners 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.

*

_____ _____

Patient / Guardian Signature Date

*

_____

If Legal Representative, State Relationship to Patient

_____

Verified By

_____

Document Type

***Required for valid Authorization**