

Authorization for Use or Disclosure of Health Info From Palomar Health Medical Group as **Medical Record custodian for Integrative Insomnia & Sleep Health Center**



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 **Palomar Health Medical Group** as **custodian of Integrative Insomnia & Sleep Health Center patients medical records** 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) _____

Authorization for Use or Disclosure of Health Info From Palomar Health Medical Group (continued)



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:

Palomar 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 Palomar 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