

Authorization for Release of Medical Records

San Diego Sports Medicine and Family Health Center

6699 Alvarado Road, Suite 2100, San Diego, CA 92120 Fax No.: (619) 582-1497
3880 Valley Centre Drive, Suite 201, San Diego, CA 92130 Fax No.: (858) 436-1289
Privacy Officer: Office Manager, Phone No. 619-229-3909

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize the use and release of health information concerning:

Patient Name: _____
Address: _____

Date of Birth: _____
Social Security No.: _____
Phone Number: _____

This health information may be disclosed by:

Doctor/Facility Name: _____
Address: _____

Phone No.: _____

This health information may be disclosed to:

Doctor/Facility Name: _____
Address: _____

Phone No.: _____

Health information to be used or disclosed (check only one box): *

- Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:

All psychotherapy notes may be released, except as specifically provided below:

The information may be used only for the following purposes (if you do not want to explain the purpose, write “At the request of the individual”):

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt. I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

This authorization is effective now and will remain in effect until _____.
(*Expiration event or date*).

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate relationship:

- parent or guardian of minor patient (to the extent minor could not have consented to the care)
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient **
- spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)

Name of patient: _____

Signature of Treating Physician (only required in the circumstances described below*):

Signed: _____ Date: _____
Treating Physician

* For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further, the LPS Act often requires that both the patient’s treating physician and the patient sign the authorization form before information may be released. Under HIPAA, an authorization for release of psychotherapy notes may not be combined with an authorization involving any other type of health information (except other psychotherapy notes).

** It is unclear whether the beneficiary or personal representative of a deceased patient can obtain and disclose certain records containing HIV test results.