

### Authorization For Use or Disclosure of Protected Health Information

When you complete and sign this form, health information about you will be released as you describe and request in the form.

---

#### Section A: Patient Information (Required)

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

---

#### Section B: Medical Records Request (Required)

- I REQUEST that my medical records FROM the facility listed below be DISCLOSED and SENT to Camino Health Center via:
- MAIL: Camino Health Center, Attn: Medical Records, 30300 Camino Capistrano, San Juan Capistrano, CA 92675
  - FAX: (949) 240-5869, Attn: Medical Records
  - I will pick up the records requested.
- I AUTHORIZE Camino Health Center to DISCLOSE my medical information to the facility listed below via:
- MAIL
  - FAX
  - I will pick up the records requested.
- Name of Person/Medical Facility: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
- I am requesting copies of my medical records for myself.
- MAIL to: \_\_\_\_\_
  - I will pick up the records requested.

---

#### Section C: Health Information to be Accessed or Disclosed (Required):

Complete Medical Record

OR the individual records marked below:

- Discharge Summary       History & Physical       Progress Notes       Treatment Plan  
 Psychosocial Assessment    Emergency Room Record    Laboratory/Pathology Reports  
 Other (Specify): \_\_\_\_\_

Access or disclosure of medical information is limited to the following:

Type of information (Specific medical condition): \_\_\_\_\_  
From (Date) \_\_\_\_\_ to (date) \_\_\_\_\_

---

## Authorization For Use or Disclosure of Protected Health Information

**\*\*Specific Authorization to Release Sensitive Records\*\***

I understand that this consent is to include disclosure of: (initial next to each)

\_\_\_\_\_ HIV/AIDS Test Results \_\_\_\_\_ Psychiatric/Mental Health \_\_\_\_\_ Alcohol and/or Drug Abuse  
 \_\_\_\_\_ Sexually Transmitted Disease Information

The purpose of the requested access or disclosure of records identified in SECTION C is for the following:

Patient Request

Other: \_\_\_\_\_

**Section D: Individual Rights**

1. You have a right to inspect and obtain a copy of your health information for as long as we maintain the information in our records, with certain limited exceptions. Under certain limited circumstances, we may deny your request to inspect and/or copy your health information. If access is denied, you may request that the denial be reviewed.
2. I understand that I may refuse to sign this authorization and that Camino Health Center may not condition my treatment upon whether I sign this authorization. I understand that if I have authorized the disclosure of information to someone who is not legally required to keep it confidential, the recipient may re-disclose it, and it may no longer be protected.
3. I understand that this authorization is effective immediately and will remain in effect until \_\_\_\_\_ (Specify date, but no longer than six months from the date of this authorization).
4. I understand that I have a right to receive a copy of this authorization.
5. I reserve the right to withdraw or revoke this authorization, in writing at any time, except to the extent that Camino Health Center has already disclosed the information.

To withdraw this authorization, submit written request to:

Camino Health Center  
 30300 Camino Capistrano  
 San Juan Capistrano, CA 92675  
 Tel: (949) 240-2272  
 Fax: (949) 240-5869

6. There may be fees associated with copying and mailing of medical records.

Patient/Patient Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by other than patient, indicate relationship: \_\_\_\_\_

If interpreted: \_\_\_\_\_

Interpreter Signature

Print Name

Language

Date

Time

Position/Relationship to Patient

**CAMINO HEALTH CENTER USE ONLY**

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_