Patient Chart # _____

Camino Health Center
Affiliated with Mission Hospital

Authorization For Use or Disclosure of Protected Health Information

Once you complete and sign this form, your health information will be shared according to your instructions.

SECTION A: PATIENT INFORMATION (REQUIRED)

Patient Name: _____ Date of Birth: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

SECTION B: MEDICAL RECORDS RELEASE PREFERENCES *(Indicate where to send or how you want to receive your medical records)*

☐ I request that my medical records be disclosed and sent to Camino Health Center via: ☐ Mail OR ☐ Fax

Mail: Camino Health Center, Attn: Medical Records, 30300 Camino Capistrano, San Juan Capistrano, CA 92675

Fax: (949) 240-5869, Attn: Medical Records

☐ I authorize Camino Health Center to disclose my medical information to the facility or individual listed below via:

☐ Mail OR ☐ Fax OR ☐ I will pick up the records in person

Name of Person/Medical Practice: _____ Fax Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

SECTION C: HEALTH INFORMATION TO BE DISCLOSED *(Let us know what part of your medical record we should send)*

☐ Complete Medical Record ☐ or as specifically indicated below:

_____

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

SECTION D: INDIVIDUAL RIGHTS

1. I understand that this authorization is effective immediately and will remain in effect indefinitely, unless an expiration date is specified here: _____

2. 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

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

Patient Signature: _____ Date: _____

Patient Representative Signature: _____ Date: _____

If signed by other than patient, indicate relationship: _____

If interpreted: _____

Interpreter Printed Name *Interpreter Signature* *Language*

_____

Date *Time* *Position or Relationship to Patient*

CAMINO HEALTH CENTER USE ONLY

Completed by: _____ Date: _____