SAN DIMAS MEDICAL GROUP, INC.
SERVING KERN COUNTY SINCE 1973

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100 Old River Road
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(661) 663-4800 Phone
(661) 663-4770 Fax
Records@sandimasmedical.com

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Chart #:_____
Address:_____ Date of Birth:_____
City/State/Zip:_____ SSN:_____
Telephone Number:_____ Maiden / Other Name:
Date of Request:_____ _____

AUTHORIZATION

I hereby authorize the use and disclosure of protected health information (PHI) about the above patient as follows:

FROM:
Person or Organization currently in possession of PHI:_____
Address of Provider:_____
City/State/Zip:_____
Phone Number:_____ Fax Number:_____

TO SEND TO:
Name of Person or Organization to receive PHI:_____
Address of Requestor:_____
City/State/Zip:_____
Phone Number:_____E-mail /Fax: _____
Purpose of request for information: ☐ Healthcare ☐ Insurance Coverage ☐ Personal
☐ Other (specify):_____

Information to be released: (Check all applicable boxes and initial selection as required)
Release only the following records or types of health information and/or only on the specified date(s):

_____ Initials ☐ Last Progress Note(s)

_____ Initials ☐ Laboratory, Pathology Reports

_____ Initials ☐ Any and all records for the last ___ years from:_____ to:_____

_____ Initials ☐ All of my health information pertaining to any medical history, physical condition and treatment received.

_____ Initials ☐ Other:_____

PHYSICIAN USE ONLY
Records reviewed and approved
_____
Signature
_____
Date

DISCLOSURE REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis or treatment for: (initial appropriate area)

_____ HIV/AIDS virus
_____ Sexually Transmitted Diseases
_____ Mental Health/Psychiatric Disorders
_____ Drug, Alcohol Abuse/Treatment

This Authorization will expire on:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

SIGNATURE

Date:_____ Time:_____ AM / PM
Signature:_____
(patient / spouse / parent / guardian / conservator / financially responsible party)

If signed by other than the patient, please indicate relationship

Witness:_____ Title:_____

FEES FOR COPYING

I understand that there could be a fee for the copying of those records **WHICH IS DUE AND PAYABLE BEFORE THE REQUEST CAN BE RELEASED TO MY POSSESSION**. Requests for medical records will be provided upon receipt of the patients signed medical release consent and payment according to the following charges:

- First five (5) pages are free, thereafter,
- $25.00 flat fee – All medical records are downloaded onto a CD. This fee includes postage, if indicated.

I understand that:

- All charges must be paid in full before releasing records.
- That in an effort to comply with the highest standings of HIPAA, our office no longer faxes medical records or protected health information.
- I may cancel this authorization, at any time, by submitting a written request to the Medical Legal address provided on this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated about could be re-disclosed.
- The recipient of medical information in California or Arizona may not further disclose medical information about me (patient) unless a new authorization form is signed by me or my personal representative or unless the disclose is specifically required or permitted by law.
- I may not be required to sign this authorization as a condition to obtain treatment or payment of my eligibility for benefits.

I may revoke this Authorization at any time by mailing or personally delivering a signed, written notice of revocation to San Dimas Medical Group, Inc. at 100 Old River Road, Bakersfield, CA 93311. Such revocation will be effective upon receipt, except to extend that the recipient has taken action in reliance on this Authorization.

I am entitled to notice if San Dimas Medical Group, Inc. will use or disclose the protected health information for marketing and receive payment for the use or disclosure of my protected health information.

ATTENTION RECIPIENT: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE

ADMINISTRATIVE PURPOSES ONLY:

Patient / Representative Identification Verified: ☐ Yes ☐ No Initials_____ Date:_____

Records reviewed:_____ Total pages:_____ Projected Cost:_____

Patient informed of cost: ☐ Yes ☐ No Initials_____ Date:_____ Time:_____ AM / PM

Amendment to original request:_____

Records are to be: ☐ Mailed ☐ Picked up by patient or patient representative

Projected total cost:_____

_____ COPY RECEIVED: I acknowledge receipt of a signed copy of this authorization
initials

Records received:_____ Date:_____

Witness:_____

PLEASE NOTE: ELECTRONIC COPIES OF THIS AUTHORIZATION WILL NOT BE ACCEPTED. YOU MUST BRING THIS FORM IN TO THE OFFICE WITH AN *ORIGINAL* SIGNATURE.