



Patient Name: _____ Date of Birth: _____

Use of disclosure: I hereby authorize Orange Coast Women's Medical Group to disclose the information listed below to: (List the person/organization authorized to receive this information.)

Name/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Non-Electronic Option: Paper CD USB
 How to receive: Mail Patient will pick up
 Authorized Representative will pick up:
 Name: _____ Phone: _____

Electronic Option: Secured Email: _____

This authorization applies to the following: Date(s) of Service: _____

- Visit Notes
- Labs ONLY
- Bone Density
- Obstetrical Records
- Other: _____
- Pap Smear
- Mammogram
- Ultrasound Report
- Surgery/Procedure (Operative Report and Pathology Report)
- HPV

I specifically authorize release of the following information (check as appropriate):

- Alcohol/drug treatment information
- HIV Test Results
- Mental Health Treatment Information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability Accountability Act (HIPAA).

Purpose for use/disclosure:

- Patient Request
- Further Medical Care
- Insurance
- OR** Other: _____

Expiration:

This authorization will expire in 1 year from date of signature unless another date is specified: _____

Signature: _____ Date: _____ Time: _____ AM/PM
[Patient/Legal Representative]

If signed by other than patient, indicate legal relationship to patient: _____

Print Name (Legal Representative): _____

Processed by: _____ Date: _____ Time: _____ AM/PM

AUTHORIZATION TO RELEASE COPIES OF MEDICAL RECORDS

Dear Patient:

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization:

Notice of Rights and Other Information:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to Orange Coast Women's Medical Group, 24411 Health Center Dr. #200, Laguna Hills, CA 92653. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance on this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality 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 may inspect or obtain a copy of the health information that I am being asked to use or disclose.

Complete request information on reverse side...

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