Authorization for Use or Disclosure of Health Info From Palomar Health Medical Group

PALOMAR HEALTH Medical Group

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

PATIENT INFORMATION	
*NAME (Last, First, M.I.)	MAIDEN OR OTHER NAME
*DATE OF BIRTH	PHONE

*Release To:

I, _____(please print) hereby authorize **Palomar Health Medical Group** to release information from or copies of my medical records to:

MYSELF

- ☐ I will pick up the records
- ☐ Email to: _____
- ☐ Mail to address on record
- ☐ Fax to: _____

PHYSICIAN OR OTHER PARTY

*NAME (Last, First, M.I.) Dr. Mashayekhi, Pegah	
STREET 3230 Waring Court Suite C	CITY Oceanside
STATE, ZIP CODE CA 92056	PHONE 858-224-1866
FAX 858-207-5042	**Email: patient@sdsleepdr.com**

***TYPE OF HEALTH INFORMATION TO RELEASE: CHECK THE BOX(ES) THAT APPLY:**

- ☐ Pertinent Reports for transferring doctors
- ☐ All medical records available. *Fee applies.* (Not to be used for transferring doctors/referrals)
- ☒ All for specific medical condition: SLEEP MEDICINE/WEIGHT MANAGEMENT
- ☐ Substance abuse ☐ Immunization record ☐ Psychiatric ☐ Mammograms
- ☐ X-ray Reports of: _____
- ☒ History and physical exam ☐ X-ray film (Fee applies) ☒ Progress notes ☐ HIV test results
- ■ Lab Test ☐ Specific date of service

***THE PURPOSE OF THIS RELEASE IS:**

- ☒ Continuing medical care ☐ Insurance ☐ Legal matter
- ☐ At my request *(fee may apply)* ☐ School ☐ Other: _____

Specify limitations (if any) on the use of the information: _____

Expiration of Authorization *Please leave this portion blank

This Authorization becomes effective upon signing and will expire **one year from date of signature,** unless specific expiration date is given: (date) _____

Authorization for Use or Disclosure of Health Info From Palomar Health Medical Group

Patient Rights

I, the patient or the patient's legal representative, understand that:

- I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered or mailed to:

  Palomar Health Medical Group
  15611 Pomerado Road Poway,
  CA 92064

If I revoke this authorization, the revocation will not have any effect on actions taken prior to Palomar Health Medical Group receiving the revocation.

- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal privacy 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 have a right to a copy of this Authorization.

*_____ _____

Signature of Patient or Patient's Legal Representative Date

*

_____

(If legal representative, state relationship to patient)

***Required for valid Authorization**

Office to complete

Action completed by:_____ **Date"**_____