HEALTH INFORMATION MANAGEMENT

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

cCARE
CALIFORNIA CANCER ASSOCIATES FOR RESEARCH & EXCELLENCE

PATIENT INFORMATION:

Patient Name: _____ SSN: _____
Please Print

Telephone Number: _____ Date of Birth: _____

INFORMATION TO BE RELEASED FROM:

I hereby authorize the release of information in my medical record from (Provider Name):

_____

_____ _____ _____ _____
Address City State Zip Code

_____ _____
Phone Fax

Including contents regarding drug or alcohol abuse, psychiatric, psychotherapy notes and HIV related (AIDS) diagnosis and/or test results. Exclusions to the above: _____

INFORMATION TO BE RELEASED TO: _____

_____

San Diego

- ☐ Pushpendu Banerjee, MD
- ☐ Alberto Bessudo, MD
- ☐ Achala Doraiswamy, MD
- ☐ Steven Eisenberg, DO
- ☐ Dawood Findakly, MD
- ☐ Edna I. Flores, MD
- ☐ Laurie Frakes, MD
- ☐ Valerie Galvan-Turner, MD
- ☐ David Hoopes, MD
- ☐ Joel M. Lamon, MD
- ☐ Martin Majer, MD
- ☐ Philip Marjon, MD
- ☐ Vir Nanda, MD
- ☐ Pallvi Popli, MD
- ☐ James Sinclair, MD
- ☐ Christopher Straka, MD
- ☐ Aparajit Venkateswaran, MD

Fresno

- ☐ Casandra Anderson, MD
- ☐ Amardeep Singh Aulakh, MD
- ☐ Sukhjeet Batth, MD
- ☐ Erin Blake, MD
- ☐ Christine Chang-Halpenny, MD
- ☐ Dexter Estrada, MD
- ☐ Sachin Gupta, MD
- ☐ Leonard T. Hackett, MD
- ☐ Steven Hager, DO
- ☐ A. Mustajeeb Haseeb, MD
- ☐ William J. Jawien, MD
- ☐ Dawn Johnson, MD
- ☐ Parham Mafi, MD
- ☐ Jedidah Monson, MD
- ☐ Rabia Parveez, MD
- ☐ Joseph Pascuzzo, DO
- ☐ Ravi D. Rao, MD

TYPE OF RECORD:

- ☐ ALL MEDICAL RECORDS (pertinent only) (limited 2 years of information)
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ Consultation Report
- ☐ Psychotherapy notes only
- ☐ Radiology reports (Specify): _____
- ☐ Lab Results
- ☐ Evidentiary Examination
- ☐ ER Report
- ☐ Other Information (Specify): _____

PURPOSE OR NEED FOR THIS INFORMATION IS:

☐ Medical ☐ Insurance ☐ Legal ☐ Personal ☐ Other: _____

CONTINUED ON BACK

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

RESTRICTIONS/DURATION/RIGHTS

- I authorize the release of the specified information from my medical records.
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality laws (HIPAA). However, under California law the requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law pursuant to state confidentiality laws.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose my information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- A photocopy of this release is as effective as the original.
- I have received a copy of this authorization.
- cCARE may receive compensation for the use or disclosure of my health information.

SIGNATURE: _____ **DATE:** _____
(Patient/Legal Representative/Guardian)

If signed by other than patient, indicate relationship: _____

Witness: _____ _____
Print Name Signature

(PHYSICIAN PART ONLY) Records obtained in the course of PSYCHIATRIC TREATMENT

The undersigned, the physician, licensed psychologist, or social worker with a master's degree in social work, hereby (approves) (disapproves) the release of information and records. Please note below any restrictions on the release of records. (Note: No approval is required for release to the patient's attorney.)

If denied, please provide reason: _____

Signature: _____ Date: _____
(Physician/Psychologist/Social Worker)

INTERPRETER SIGNATURE IF APPLICABLE:

I have accurately and completely read the foregoing document to _____
Patient's or Legal Representative's name

in _____, the patient's or legal representative's primary language.
Language

(He/She) understood all the terms and conditions and acknowledged (his/her) agreement thereto by signing the document in my presence.

Interpreter's Name: _____ Signature: _____

SAN DIEGO Medical Records:	Phone: 760.747.8935	Fax: 760.747.7951
FRESNO Medical Records:	Phone: 559.326.1222 x4015	Fax: 559.326.1233