AUTHORIZATION FOR USE AND DISCLOSURE

AltaMed

Failure to complete all sections of this form may invalidate this request.

Patient/Participant/Client Information			
Patient's Last Name:		Phone Number:	DOB:
Patient's First Name:		E-Mail Address:	
Entity/Person To Disclose PHI		**Entity/Person To Receive PHI**	
Name:		Name:	
Address:		Address:	
City:	Zip:	City:	Zip:
Phone:	Fax:	Phone:	Fax:

PURPOSE OF INFORMATION TO BE RELEASED:

☐ Personal Use ☐ Changing Physicians ☐ Legal Investigation

☐ Continuity of Care ☐ Insurance Eligibility/Benefits ☐ Other: _____

DATES OF SERVICE:

From: ____/_____/_____ **To:** ____/_____/_____ **OR** ☐ **All Dates of Service**

TYPE OF INFORMATION TO BE RELEASED:

☐ Clinic Records ☐ Immunization History ☐ Laboratory Results

☐ Dental Records ☐ Billing Records ☐ Radiology Results/Images

☐ OB/GYN Records ☐ HIV Test Results ☐ Reproductive Health

☐ STD Lab Results ☐ Entire Medical Record ☐ Other: _____

METHOD FOR PROCESSING RELEASE:

☐ Mail to Patient Address Listed Above ☐ MyAltaMed Patient Portal

☐ Other (Please Specify):_____ ☐ E-Copy Encrypted (CD, Flash Drive)

☐ Patient/Designee/Legal Representative to Pick Up

If picked up by someone other than patient write individual name: _____

EXPIRATION: I understand that this authorization will be in effect until:

Expiration Date: _____/_____/_____ **or Event:** _____.

If there is no expiration date this authorization will expire 6 months after the date of signature.

PATIENT LABEL HERE

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RESTRICTIONS: I understand that the information released with this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. California law prohibits the requestor from making further disclosure of your health information unless the requestor obtains another authorization from you or unless such disclosure is specifically required or permitted by law.

PATIENT RIGHTS: I understand I have a right to receive a copy of this authorization. AltaMed will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I provide authorization for the requested release, unless as otherwise specifically required or permitted by law.

CANCELLATION of AUTHORIZATION: You may cancel this authorization at any time. If you choose to do so, it must be done in writing and signed by you or your legal representative and sent to the following address: AltaMed Health Services, Attn: Health Information Management Director, 2040 Camfield Avenue, Commerce, CA 90040. The HIM Director may be reached at 323-622-2444 for authorization-related questions, concerns, or complaints.

If signed by someone other than patient, indicate relationship:

☐ Parent/Legal Guardian ☐ Personal/Legal Representative

☐ Caregiver ☐ Durable Power of Attorney

☐ Other (Please Specify):_____

AUTHORIZATION:

_____ ____/_____/_____

Patient Printed Name Date

_____ ____/_____/_____

Signature Date

PATIENT LABEL HERE