

Authorization for Release of Medical Records

San Diego Sports Medicine and Family Health Center

6699 Alvarado Road, Suite 2100, San Diego CA 92120, Phone No.: (619) 229-3909, Fax No.: (619) 814-5412
4010 Sorrento Valley Blvd., Suite 300, San Diego CA 92121, Phone No.: (858) 793-7860, Fax No.: (858) 436-1289
1945 Garnet Ave., San Diego CA 92109, Phone No.: (858) 224-7977, Fax No.: (858) 224-7978
Privacy Officer: Phone No. (619) 229-3909

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize the use and release of health information concerning:

Patient Name: _____

Address: _____

Phone Number: _____

Date of Birth: _____

Social Security No.: _____

This health information may be disclosed by:

Doctor/Facility: _____

Address: _____

Phone Number: _____

Fax Number: _____

This health information may be disclosed to:

Doctor/Facility: _____

Address: _____

Phone Number: _____

Fax Number: _____

Health information to be used or disclosed (check only one box): *

- Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:

- All psychotherapy notes may be released, except as specifically provided below:

The information may be used only for the following purposes (if you do not want to explain the purpose, write “At the request of the individual”):

I understand that I may revoke this authorization at any time in writing. My revocation will not affect actions taken by this medical practice prior to its receipt. I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

This authorization is effective now and will remain in effect until _____.
(*Expiration event or date*).

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate relationship: _____