Authorization For Use By or Disclosure of Health Information To 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	TELEPHONE

*Release To:

I, (the patient) _____ **(please print)** hereby authorize my doctor/hospital to release my medical records to Palomar Health Medical Group.

FROM: DOCTOR/HOSPITAL NAME		
STREET/ADDRESS		
CITY	STATE	ZIP CODE
PHONE	FAX	

To:

Palomar Health Medical Group
15611 Pomerado Road, Suite 400
Poway, CA 92064
Phone: 858.675.3199 Fax: 858.673.5187

*Type of Health Information to Release:

Transfer of Records for Change of Primary Care Physician.

- Problem List
- H&P
- Most recent progress notes
- Immunization Record
- Last Colonoscopy Report
- Most recent lab reports
- All diagnostic studies
- Medication list
- Operative Reports

Genetic Testing _____

Records pertinent to specific medical condition _____

Psychiatric/Substance Abuse HIV test

Radiology images/film of [test] _____

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PALOMAR HEALTH Medical Group

***The purpose of this release is:** to provide information to our medical staff to aid in your continuing medical care.

Other: _____

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

Expiration of Authorization

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

Patient Rights

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

- This authorization is voluntary. Palomar Health Partners may not condition treatment on my signing this form. I, or my legal representative, may refuse to sign.
- 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 will be provided with 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**