Bakersfield Family Medical Center/Coastal Communities Physician Network
HIM Department, 4580 California Avenue, Bakersfield, CA 93309
661-327-4411

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I authorize ____
(Name and address of physician or health care provider authorized to use or disclose information)

To furnish to ____
(Name and address of person/organization to which disclosure is made)

Health information described below on: ______________________________
(*Patient name)*

For the purpose of: ____

This information is limited to the following type and amount of information. (Use dates where appropriate).

- €Progress Notes
- €Consultation Reports
- €Laboratory, Pathology Reports
- €Radiology Reports/Imaging Reports
- €Immunization Records
- €Any and all records for the last 2 years
- €Medical Records relating to injury
- €Other: ______________________

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis or treatment for: (*initial appropriate area*)

HIV/AIDS virus______________________
Sexually Transmitted Diseases__________
Mental Health/Psychiatric Disorders__________
Drug, Alcohol Abuse/Treatment_____________

I understand that I have a right to revoke this authorization at any time. I understand that my revocation must be in writing and presented to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

Treatment, payment, enrollment and/or eligibility for benefits will not be conditioned on me providing or refusing to provide this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information Management. I understand I have a right to receive a copy of this authorization.

____
Signature of Patient, Parent or Legal Guardian

____
Patient Date of Birth

____
If signed by other than patient, indicate relationship

____
Patient Address

____

____
Patient telephone number

____
Witness signature

____
Date

BFMC-301 (rev 01-2016)

PLEASE RETAIN A COPY OF YOUR SIGNED AUTHORIZATION.