Coastal Communities Physician Network
P.O. Box 13659, San Luis Obispo, CA 93406-3659
800-604-8752

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_____ Mental Health/Psychiatric Disorders_____
Sexually Transmitted Diseases_____ 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

PLEASE RETAIN A COPY OF YOUR SIGNED AUTHORIZATION.