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Acacia
FAMILY MEDICAL GROUP

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

REQUEST FOR RELEASE OF MEDICAL RECORDS FROM:

_____
Name of Individual or Organization

_____
Address

_____
City, State, Zip

TO:

_____
Name of Individual of Organization

_____
Address

_____
City, State, Zip

This authorization permits the sender to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, type of services, level of detail to be released, origin of information, etc.):

_____

_____

The information will be used or disclosed for the following purpose:

_____Clinical Care_____

If requested by the patient, purpose may be listed as ñat the request of the individual.ò The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on:_____1 Year_____
Expiration Date or Defined Event

The Practice will__ will not_X_receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **Acacia Family Medical Group.** In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: **400 E. Romie Lane**
Salinas Ca, 93901

Signed by: _____ _____
Signature of Patient or Legal Guardian *Relationship to Patient*

Print: _____ _____
Print Name of Patient//Legal Guardian *Date of Birth*

_____ _____
Other Names Used by Patient *Date*

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION