☐ Hoag Medical Group ☐ Hoag Urgent Care ☐ Hoag Physician Partners ☐ Hoag Concierge Medicine ☐ Hoag Specialty Clinic

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION (INCOMING RECORDS)

Patient Name: _____ Date of Birth: _____

Use of disclosure: I hereby authorize:

Name/Organization: _____ Attention: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

To release copies of my records to:

Hoag Health Information
One Hoag Drive, P.O. Box 6100, Newport Beach, CA 92658-6100
Attention: Medical Records
Phone: (949) 764-4624, Ext. 54001
Fax: (949) 764-8237
Email: HoagMedicalRecords@hoag.org
Requesting Provider: _____

This authorization applies to the following:

☐ Only the following records or types of health information: Date of service: _____
If no dates are entered, only the last 2 years will be released.

☐ Labs ☐ History and Physical ☐ Progress Notes ☐ Consultation Notes ☐ Other: _____
☐ All health information pertaining to any medical history, physical condition, and treatment received

I specifically authorize release of the following information (check as appropriate):

☐ Alcohol/drug treatment information ☐ HIV Test Results ☐ Mental Health Treatment Information

A separate authorization is required to authorize disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability Accountability Acct (HIPAA).

Purpose for Use/Disclosure:

☐ Further Medical Care ☐ Other: _____

Expiration:

This authorization will expire in 1 year from date of signature unless another date is specified: _____

Signature: _____ Date: _____ Time: _____ AM/PM
[Patient/Legal Representative]

If signed by other than patient, indicate legal relationship to patient: _____

Print Name (Legal Representative): _____

Witness Signature: _____ Date: _____ Time: _____ AM/PM

REQUEST TO OTHER PROVIDERS TO RELEASE COPIES OF MEDICAL RECORDS

Dear Patient:

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization:

Notice of Rights and Other Information:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the facility/provider listed on page 2. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance on this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality 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 may inspect or obtain a copy of the health information that I am being asked to use or disclose.

Complete request information on reverse side...