**I authorize information to be released to: Records From:**

|  |  |
| --- | --- |
| Name of Facility:  Fortuna Family Medicine Inc. | Name of Facility: |
| Address:  2404 Newburg Rd. | Address: |
| City, State, Zip:  Fortuna, CA 95540 | City, State, Zip: |

|  |  |
| --- | --- |
| Phone: | Fax: |

**Purpose of release: (circle all that apply)**

Medical Care Personal Legal Other:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of information to be released (records will be limited to the last two years unless otherwise indicated):**

* General Health Records (physician reports, diagnostic reports, hospital reports, lab/pathology reports, consultation reports, immunizations)
* Workers Comp. Injury Initial:\_\_\_\_\_\_\_\_\_\_\_
* PT/OT Reports Initial:\_\_\_\_\_\_\_\_\_\_\_
* HIV/Aids Treatment Initial:\_\_\_\_\_\_\_\_\_\_\_
* Mental Health Treatment Initial:\_\_\_\_\_\_\_\_\_\_\_
* Drug/Alcohol Treatment Initial:\_\_\_\_\_\_\_\_\_\_\_
* Genetic Testing Information Initial:\_\_\_\_\_\_\_\_\_\_\_

**Authorization Information:**

I understand the following:

1. I authorize the use or disclosure of health information as described above for the purpose listed. I understand this authorization is voluntary.

2. I have the right to revoke this authorization. To do so I understand I must submit my revocation in writing to the party entered in Part II. The revocation will prevent further release of my health information from the date of receipt.

3. I am signing this authorization voluntarily and understand my health care treatment will not be affected if I do not sign this authorization.

4. The party entered in Part III is prohibited from re-disclosing the health information except with a written authorization or as specifically permitted by Cal. Code §56.10 or required by law (applies within California only).

5. If the party entered in Part III is not a HIPAA Covered Entity or Business Associate as defined in 45 CFR §160.103, the released health information may no longer be protected by federal and state privacy regulations.

6. I have a right to receive a copy of this authorization.

7. Fees may be charged to cover the cost of releasing the health information.

8. I understand that my substance abuse disorder records are protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be redisclosed without my written authorization.

**Patient Information and Signature:**

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient of legal representative Relationship to Patient Date