

GOOD MEDICINE  
 101 Old McCloud Road, Mt Shasta, CA 96067  
 Phone (530) 926-5100 Fax (530) 926-1859  
Authorization for Use or Disclosure of Protected Health Information

Patient's Name \_\_\_\_\_ Phone # \_\_\_\_\_

AKA \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

**I authorize the use or disclosure of the above-named individuals health information as described below:**

PLEASE INITIAL ALL TYPES OF INFORMATION TO BE USED OR DISCLOSED AND FILL IN THE SPECIFIC DATES OF SERVICE REQUESTED

_____ recent and current problem list	_____ recent and current medication list
_____ a list of current allergies	_____ immunization records
_____ recent history and physical examination	
_____ progress notes from _____	to _____ (dates)
_____ laboratory results from _____	to _____ (dates)
_____ x-ray or imaging reports from _____	to _____ (dates)
_____ consultation reports from _____	(doctor's name)
_____ other (please specify) _____	

Disclosure of information to be made **from:**

Disclosure to be made **to:**

\_\_\_\_\_  
 (Name of facility in possession of information)

\_\_\_\_\_  
 (Name of person/facility records are to be released to)

\_\_\_\_\_  
 (Mailing address)

\_\_\_\_\_  
 (Mailing address)

\_\_\_\_\_  
 (City & state)

\_\_\_\_\_  
 (City & state)

This protected health information is being used or disclosed for the following purposes( Please Initial):

\_\_\_\_\_ At the request of the individual, or  
 \_\_\_\_\_ Continuity of care  
 \_\_\_\_\_

This authorization shall be in force and effect until \_\_\_\_\_ at which time this authorization to use or disclose this protected health information expires. If I fail to specify an expiration date, this authorization will expire in six months.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at 101 Old McCloud Road, Mt Shasta, CA 96067. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition by treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

**I understand that there may be a fee charged for processing this request.**

\_\_\_\_\_  
 Signature of Patient or Personal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Print Name of Patient or Personal Representative

\_\_\_\_\_  
 Description of Personal Representative's Authority