The Priority Care Center

A Program of the Humboldt IPA

P: (707) 442-0478 F: (707) 443-2527

AUTHORIZATION TO USE, DISCLOSE, AND REALEASE PROTECTED HEALTH INFORMATION

I authorize: _____

_____

(Provider or Facility name, Address, Phone number, and Fax Number)

- ☐ to release and discuss health information to:
- ☐ to release and discuss health information from:

The Priority Care Center

2316 Harrison Avenue Eureka, CA 95501 Fax:707-443-2527

IF REQUESTING PATIENT RECORDS INDICATE BELOW THE INFORMATION TO BE RELEASED

PCC to Check ALL that apply:

☐History, Physical Exams, Progress Notes, Chart Summary **Last 12 months**	☐Specialist Progress Notes **Last 12 months**	☐Last Colonoscopy, Cologuard, FOBT ☐Last Pap ☐Last Mammogram ☐Last Hemoglobin A1c
Diagnostic Testing: ☐Lab Results ☐Radiology Reports ☐Diagnostic Reports ☐Pathology Reports **Last 12 months**	**Hospital:** ☐Outpatient Clinic Records ☐Inpatient Notes/ Discharge ☐Operative Reports ☐Emergency Notes/ Discharge **Last 12 Months**	**Sensitive Materials:** ☐Drug and Alcohol Abuse ☐HIV/AIDS Results/ Treatment ☐Psychological/ Vocational: Testing/Notes ☐Medical information related to gender affirming care, abortion and abortion-related services, and contraception.
☐Specific/ Other:		

-Include a specific time frame FROM: _____ **TO:** _____

Expiration of Authorization:

Unless otherwise revoked, this Authorization expires _____(insert applicable date or event). If no date is indicated, this Authorization will not expire after signing this form.

Note: Authorizations to disclose your information to an employer or financial institution can only be effective a maximum of ninety (90) days from the date you signed this form.

Signature of Patient or Patient's Legal Representative Date

Printed Name Date of Birth Phone Number

NOTICE

Humboldt Independent Practice Association (IPA), The Priority Care Center and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure or release of health information to someone who is not legally required to keep it confidential, it may no longer be protected by state and federal confidentiality laws.

MY RIGHTS

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine the entity's obligation to pay a claim, or 4) to create health information to provide to a third party.
- I may revoke this authorization at any time, provided I do so in writing and submit it to the Health Information Compliance Officer, Humboldt Independent Practice Association, 2315 Dean St, Eureka, CA 95501. The revocation will take effect when the Humboldt Independent Practice Association receives it, except to the extent that the Humboldt Independent Practice Association or others have already relied on it.
- I am entitled to receive a copy of this Authorization.