The Priority Care Center

A Program of the Humboldt IPA
2316 Harrison Ave, Eureka
P: (707) 442-0478 F: (707) 443-2527

AUTHORIZATION TO USE, DISCLOSE & RELEASE PROTECTED HEALTH INFORMATION

I authorize:
Provider/Facility Name: _____
Address/City/State _____
Phone: _____ **Fax**: _____

To release health information ☐ **To** ☐ **From:**

The Priority Care Center

2316 Harrison Avenue Eureka, CA 95501

PLEASE ONLY SEND PATIENT RECORDS INDICATED BELOW:

(NOTE: Please do NOT send Progress notes, unless indicated below)

Reason for disclosure: ☐ Transfer of Care ☐ Treatment ☐Sharing information with another doctor treating me. ☐ Coordination of Care

☐ Radiology and other Diagnostic reports	☐ Laboratory Reports (last 2 years)	☐ Pathology Reports
☐ Most recent problem list	☐ Most recent medication list	☐ Specialist Consult note for _____
☐ Pap smear results	☐ Colonoscopy results	☐ Retinopathy eye exam
☐ Mental health problem list, medication list and last progress note	☐ Substance use disorder treatment notes, including labs and toxicology results	☐ Psychiatry Consultation Notes
Other: _____		

ATTENTION RECIPIENT – Notice Prohibiting Redisclosure

This information has been disclosed to you from the records protected by Federal confidentiality rules 42 C.F.R Part 2. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug client.

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EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event). If no date is indicated, this Authorization will expire 12 months after the date of signing this form.

(Note: If this authorization is to disclose your information to an employer or financial institution, it 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, 2662 Harris St, Eureka, CA 95503. 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.