



The Priority Care Center

A Program of the Humboldt IPA
P: (707) 442-0478 F: (707) 443-2527

AUTHORIZATION TO USE, DISCLOSE, AND RELEASER 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:

<input type="checkbox"/> History, Physical Exams, Progress Notes, Chart Summary Last 12 months	<input type="checkbox"/> Specialist Progress Notes Last 12 months	<input type="checkbox"/> Last Colonoscopy, Cologuard, FOBT <input type="checkbox"/> Last Pap <input type="checkbox"/> Last Mammogram <input type="checkbox"/> Last Hemoglobin A1c
Diagnostic Testing: <input type="checkbox"/> Lab Results <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Diagnostic Reports <input type="checkbox"/> Pathology Reports Last 12 months	Hospital: <input type="checkbox"/> Outpatient Clinic Records <input type="checkbox"/> Inpatient Notes/ Discharge <input type="checkbox"/> Operative Reports <input type="checkbox"/> Emergency Notes/ Discharge Last 12 Months	Sensitive Materials: <input type="checkbox"/> Drug and Alcohol Abuse <input type="checkbox"/> HIV/AIDS Results/ Treatment <input type="checkbox"/> Psychological/ Vocational: Testing/Notes
<input type="checkbox"/> Specific/ Other:		

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

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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 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.

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