

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

PATIENT INFORMATION	
*NAME (Last, First, M.I.)	MAIDEN OR OTHER NAME
*DATE OF BIRTH	PHONE

## \*Release To:

I, \_\_\_\_\_\_(please print) hereby authorize Palomar Health Medical Group as custodian of Integrative Insomnia & Sleep Health Center patients medical records to release information from or copies of my medical records to:

MYSELF	PHYSICIAN OR OTHER PARTY		
☐ I will pick up the records	*NAME (Last, First, M.I.)		
Email to:	STREET CITY		
☐ Mail to address on record	STATE, ZIP CODE PHONE		
□ Fax to:	FAX 858-673-5187 Email: medicalrecords@phmg.org		
*TYPE OF HEALTH INFORMATION TO RELEASE: CHECK THE BOX(ES) THAT APPLY ease see the attachment for ROI fo			
Pertinent Reports for transferring doctors			
All medical records available. <i>Fee applies.</i> (Not to be used for transferring doctors/referrals)			
All for specific medical condition:			
□ Substance abuse □ Immunization record □ Psychiatric □ Mammograms			
🗆 X-ray Reports of:			
☐ History and physical exam ☐ X-ray film	n (Fee applies)		
Lab Test Specific date of service			
*THE PURPOSE OF THIS RELEASE IS:			
Continuing medical care	nce 🗌 Legal matter		
At my request <i>(fee may apply)</i>	ol 🗌 Other:		
Specify limitations (if any) on the use of the information:			

### **Expiration of Authorization**

This Authorization becomes effective upon signing and will expire one year from date of signature, unless specific expiration date is given: (date) \_\_\_\_\_

# Authorization for Use or Disclosure of Health Info From Palomar Health Medical Group (continued)



### **Patient Rights**

I, the patient or the patient's legal representative, understand that:

> I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered or mailed to:

Palomar Health Medical Group 15611 Pomerado Road Poway, CA 92064

If I revoke this authorization, the revocation will not have any effect on actions taken prior to Palomar Health Medical Group receiving the revocation.

- > Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal privacy law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- > I have a right to a copy of this Authorization.

Signature of Patient or Patient's Legal Representative	Date
*	
(If legal representative, state relationship to patient)	
Action completed by	
PHI log completed	

#### \*Required for valid Authorization