Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous/Maiden Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Street/P.O. Box) (City) (State) (Zip)

PMG MRN # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Kaiser #: (If Applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Records will be disclosed FROM (*Name of Physician or Facility)*:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(City)  (State) (Zip) Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Records will be disclosed TO (*Name of Physician or Facility)*:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(City)  (State) (Zip) Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please send the following records for this period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIMITATIONS**: The information to be released is limited to:

❑ **All Medical Records (PMG’s policy is the last 2 years and pertinent for continued care)**

❑ History Progress Notes ❑ Laboratory/ Pathology Reports ❑ X-ray / EKG Reports ❑Other

❑ Physical Examinations ❑ GYN Records ❑ Immunization History \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SPECIFIC AUTHORIZATIONS:** The following information will not be released without your specific authorization by checking the relevant box(es) below:

❑ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment. (42 C.F.R. §§ 2.34 and 2.35)

❑ I specifically authorize the release of information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§ 5328, et seq.)

❑ I specifically authorize the release of HIV/AIDS test results. (Health and Safety Code §§ 120980(g)).

**Expiration Date of Authorization:**

This authorization is effective through \_\_\_/\_\_\_/\_\_\_ unless revoked or terminated by the patient or the patient’s representative. (If no date is indicated, this authorization will expire 12 months after the date of signing this form.)

**Right to Terminate or Revoke Authorization:**

You may revoke or terminate this authorization by submitting a written revocation to Providence Medical Group. You should contact the Office Manager to terminate this authorization.

**Potential for Re-Disclosure:**

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Copies of this signed authorization form are considered as valid as the original. Upon request a copy of this form will be given to the patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient/Patient Legal Representative Date Relationship to Patient**

**Autorización Para el Uso o Compartir Información Médica Protegida**

*(Office Staff: When requesting records, please enclose a blank English version for translation purposes.)*

Nombre del Paciente: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha de Nacimiento: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Otros Nombres/Nombre de soltera: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teléfono: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dirección Postal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Calle/Caja Postal) (Ciudad) (Estado) (Código Postal)

PMG MRN # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Kaiser #: (Si aplíca) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Pedir información médica DE (*Nombre del doctor o clínica)*:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dirección Postal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Ciudad) (Estado) (Código Postal) Teléfono: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Compartir información médica CON (*Nombre del doctor o clínica)*:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dirección Postal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Ciudad) (Estado) (Código Postal) Teléfono: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Por favor de compartir información acerca de tratamiento médico durante fechas: \_\_\_\_\_\_\_\_\_\_\_\_ a \_\_\_\_\_\_\_\_\_\_\_\_

**INFORMACIÓN LIMITADA A**:

❑ **Todo mi expediente médico (Policía de PMG es compartir 2 años de tratamiento médico.)**

❑ Notas de citas ❑ Reportes de Laboratorio ❑ Reportes de Radiografía/EKG ❑Otro

❑ Exámenes Físicos ❑ Reportes Ginecológicos ❑ Historia de Vacunas \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTORIZACIONES ESPECÍFICAS:** La siguiente información no será compartida sin autorización específica y con marcar la caja(s) abajo:

❑ Autorizo compartir información sobre el abuso, diagnóstico, o tratamiento de drogas y alcohol. (42 C.F.R. §§ 2.34 and 2.35)

❑ Autorizo compartir información sobre el diagnóstico o tratamiento de una condición mental/psicológica. (Welfare and Institutions Code §§ 5328, et seq.)

❑ Autorizo compartir información sobre los resultados del análisis de sangre para VIH/SIDA. (Health and Safety Code §§ 120980(g)).

**Fecha de vencimiento de esta autorización:**

Esta autorización se vence en \_\_\_/\_\_\_/\_\_\_ al menos que el paciento o su representante la suspenda antes de la fecha notada. (Si no se nota una fecha de vencimiento, esta autorización se vence en 12 meses.)

**Derecho de suspender esta autorización:**

Tiene el derecho de suspender esta autorización con presentar una carta en escrito a Providence Medical Group y al supervisor de la oficina médica.

**Posibilidad de re-divulgación:**

Información compartida como resultado de esta autorización puede ser compartida de nuevo por la persona u organización a donde mandamos esta información. Es posible que su información no sea protegida por las leyes federales de privacidad.

Una copia de esta autorización se considera igual al original. Puede pedir una copia de esta autorización.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Firma del Paciente/Firma del Representante Legal Fecha Relacción al Paciente**