

**Authorization for Use or Disclosure of Protected Health Information
North Coast Family Medical Group, Inc.**

477 N. El Camino Real, Suite A306, Encinitas, CA 92024
(760) 942-0118 Phone (760) 942-5319 Fax

As required by the Health Information Portability and Accountability Act ("HIPAA") of 1996 and California law, North Coast Family Medical Group, Inc. may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving your permission for the uses and disclosure described below. Please be aware that once your information leaves North Coast Family Medical Group, Inc., we will no longer be able to protect that information and the recipients of your information may not be legally required to protect your information. I hereby release North Coast Family Medical Group, Inc. from any and all legal liabilities that may arise from the release of this information to the party listed below.

I hereby authorize North Coast Family Medical Group, Inc. to obtain or disclose health information concerning:

Patient's Name

Date of Birth

Health Information to be used or disclosed (check appropriate box(es):

- Entire Medical Record
- History/Physical Exams Consultation Reports Progress Notes Laboratory Test
- X-Ray Results Telephone Messages Medication Prescribed Psychotherapy Notes
- Only dates of service from _____ to _____

I understand this information may include information relating to mental health diagnosis and treatments, AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, STD's (Sexually Transmitted Diseases) or other communicable diseases and counseling and/or treatment for alcohol and/or drug use/or abuse.

Therefore, **I DO / DO NOT** authorize the release of this type of information.

The requestor may use medical records and type of information authorized only for the following purposes:

- Continuing Care Inspection of Record Legal Matter
- Insurance Claim Personal Copy Second Opinion
- Other (Please Specify): _____

Transfer of Information:

Physician or Facility Name and Address:

Information May be released to:
North Coast Family Medical Group
477 N. El Camino Real #A306
Encinitas, CA 92024

Cancellation Notice: Records Releases are accomplished in as little as 2-3 days, but no longer than 15 days. You have a right to withdraw your authorization. I Understand authorization may be revoked in writing at any time, according to the North Coast Family Medical Group, Inc. Notice of Privacy Practices. Unless otherwise revoked, this information will expire six (6) months from the date of this authorization.

*After medical provider review, patients will be notified that records from outside facility will be destroyed unless picked up within 10 days of notification. A minimum \$5.00 fee applies to requests to mail and may increase depending on postage.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient –
I here by declare under penalty of perjury, that I am the natural or adoptive parent or legal guardian of said child and there is no court order restricting or prohibiting my access to such medical records.
- Guardian or conservator of an incompetent patient or representative of deceased patient

Name of Patient: _____ Date of birth: _____

{office use only below}

- Patient Will Pick up. Date of pick up _____
- Call when ready (phone #): _____