Palo Alto Medical Foundation
A Sutter Health Affiliate

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth_____
Dates of Service:_____ Phone Number_____

I authorize (Name and address):

_____

to release to (Name and address of recipient):

_____

the following health information:

❑ Discharge Summary	❑ Outpatient Clinic Records	❑ Immunization Records
❑ Inpatient Progress Notes	❑ Emergency Record	❑ Same Day Surgery Record
❑ History & Physical	❑ Laboratory Test(s)	❑ Complete Medical Record
❑ Operative Report	❑ Radiology Report(s)	❑ Other:_____
❑ Consultation Report	❑ Pathology Report(s)	_____
		_____

Please include restricted access information relating to *(initial if needed)*:

_____ HIV test results _____ Behavioral Health _____ Genetic Testing

The recipient may use my health information only for the following purpose(s:)

_____

EXPIRATION: This authorization shall become effective immediately and shall remain in effect until *(enter specific date)*: _____. If no date is given, the authorization will be valid for one year from the date of signing.

RESTRICTIONS: California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

YOUR RIGHTS:

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address:

  _____
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have a right to receive a copy of this authorization (required if authorization is requested for the provider's use or disclosure of health information).

- I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.
- If this box ❑ is checked _____ will receive compensation for the use or disclosure of my health information.

SIGNATURE:

_____

Signature (Patient/Representative) Date Time

_____

If signed by other than patient, print name and relationship

When completed, check the box below for your medical group and send to the corresponding ACTA Medical Services Inc.

Camino Medical Group
701 E. El Camino Real
Mountain View, CA 94040
Phone: (408) 523-3267
Fax: (408) 524-5034

Palo Alto Medical Clinic
795 El Camino Real
Palo Alto, CA 94301
Phone: (650) 853-4745
Fax:(650) 853-6093

Santa Cruz Medical Foundation
2880 Soquel Ave., Ste. 1
Santa Cruz, CA 95062
Phone: (831) 458-5520
Fax: (831) 479-6636

Clinic use only below this bar

BEHAVIORAL HEALTH INFORMATION

If the health information requested pertains to behavioral health information, the undersigned physician, licensed psychologist, or social worker with a master's degree in social work who is in charge of the patient:

❑ Approves

❑ Disapproves

the disclosure of the health information and records described above. If disclosure is approved, any restrictions are listed below. If disclosure is disapproved, the reasons are stated below:

_____

_____

Date: _____ Time:_____

Signature: Physician/Psychologist/Social Worker_____

Applicable Fees:	Clerical	Copying	Delivery
Delivered to a Health Care Provider			
Delivered to Non-Provider (3rd party)			