



SADDLEBACK MEDICAL GROUP

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I, the undersigned, hereby authorize the Disclosure Exchange Request of the following Protected Health Information (Medical Records):

PHI From:	Disclose PHI To: <input type="checkbox"/> Facility <input type="checkbox"/> Patient
Name of Facility Producing Records	Name of Facility/ Patient Receiving Records
Street Address / Mailing Address	Street Address / Mailing Address
City, State, Zip	City, State, Zip
Phone Number Fax Number	Phone Number Fax Number

An authorization to disclose Protected Health Information (PHI) is voluntary. Treatment, payment, or eligibility for benefits will not be affected if you do not sign this authorization. Redisclosure of a person's PHI is prohibited without the specific written authorization of that person or as otherwise permitted by state or federal law. Information disclosure pursuant to this authorization may be disclosed by the recipient and no longer be protected by California or federal law.

PHI TO BE DISCLOSED: (Please check all that apply and identify clinic and time period as necessary.)

Summary of Patient Health Records PHI _____

Mental Health PHI / Psychotherapy Notes (Date of Service) _____

Alcohol/Substance Abuse Treatment PHI (Date of Service) _____

Urine Test Progress in Treatment Dates of Attendance

HIV Results / AIDS Treatment PHI: _____

Billing Records: (Date of Service) _____ Medical Records: (Date of Service) _____

The information to be released from my medical records shall be limited to:

The reason for requesting that my medical records be copied is:

- Change insurance Second opinion Personal Use
- Change doctor Unhappy with Care/Service Legal Case
- Moving out of area Accident/Third party liability Other _____

UNLESS OTHERWISE REVOKED IN WRITING, THIS AUTHORIZATION EXPIRES ON:

Completion of this request (one time disclosure) Six months from signature date below

Expires as specified: _____

There is a charge for copying your medical records and transferring them to another physician outside of Saddleback Medical Group. *The charge starts @ \$25.00 plus postage.* (This charge covers clerical cost and materials used to produce the records). Our medical record personnel will assist you with the processing of your request. *Picking up your medical records is by appointment only.* Please allow at least 48 hours to process your request. **I agree to pay this reasonable charge to cover the cost of clerical cost incurred in making the medical records available.**

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number : _____ Email: _____ Date: _____

Signature: _____ Relationship to Patient: _____

* Authorized representative must submit copies of legal documents supporting assignment of this authority, i.e. POWER OF ATTORNEY. This authorization for use of disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56, et. seq., California Civil Code, Effective January 1, 1983. California law guarantees patients access to their medical care and specifies available procedures. Health & Safety Code 1795 et. seq. declares that "every person having ultimate responsibility for decisions respecting his/her own health care also possesses a concomitant right of access to complete information respecting his/her condition and care provided." In compliance with California's Health & Safety Code 1795.12, it is our policy to allow current and former adult patients, parents of minor patients (with exceptions), patient guardians or conservators, and deceased patient's beneficiaries or personal representatives to inspect the patient's medical records within five working days after receiving a written request or to ensure that copies are transmitted within 15 days after receipt of the written request and payment of reasonable clerical costs.