THE CENTER FOR HEALTH & WELLBEING
3636 Fifth Avenue
Suite 300
San Diego, CA 92103

INTERNAL MEDICINE
FAMILY PRACTICE
NATUROPATHIC MEDICINE
CHIROPRACTIC
HEALTHY AGING

ACUPUNCTURE
NAD IV THERAPY
IV NUTRIENT THERAPY
WEIGHT MANAGEMENT
HORMONE THERAPY

HILLCREST
P +1 (619)814-5500
F +1 (619)794-0260
www.chwbonline.com

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Name of patient: _____ DOB:_____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____

to release to: _____

_____

(Persons/organizations authorized to receive the information) (Address, street, city, state, zip code)

Phone: _____ Fax: _____

a. The following information is to be released:
- □ Assessment/history and physical - Date(s) of service: _____
- □ Discharge summary - Date(s) of service: _____
- □ Lab tests - Date(s) of service: _____
- □ Radiology reports - Date(s) of service: _____
- □ Entire record - Date(s) of service: _____
- □ Other (please specify needed information and date[s] of service if known): _____

_____

b. I specifically authorize the release of the following information (check as appropriate):
- □ Mental health treatment information[1] **(A separate authorization is required to authorize the disclosure or use of psychotherapy notes.)**
- □ HIV test results
- □ Alcohol/drug treatment information
- □ Genetic information/testing

Patient's Initials
_____ I understand that the information in my medical record may include information relating to sexually transmitted disease, acquitted immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization, I am authorizing the release of such information unless specified otherwise above.

Patient's Initials
_____ I understand my treatment or payment of my treatment cannot be conditioned on the signing of this authorization.

Patient's Initials
_____ Any facsimile, copy, or photocopy of this authorization shall authorize you to release the records requested herein.

Patient's Initial
_____ There is a fee of $45 for records provided to patients upon written request and signed authorization. Records sent directly to another physician will have reproduction fee discounted as a professional courtesy.

Our Core Values

- A Healing Environment
- A Caring Team of Professionals
- A Partner in Your Optimal Health
- The Quality Care You Deserve

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PURPOSE

The purpose of the release of this information is:

- □ Insurance or other third-party reimbursement
- □ Continuity of medical care
- □ Pending legal action
- □ At the request of the patient
- □ Other: (Specify) _____

RESTRICTIONS

According to federal and state regulations, if the medical information requested relates to AIDS/HIV treatment or treatment in a federally recognized chemical dependency unit, then the information will be accompanied by a statement limiting disclosure to third parties as required by law.

I understand that if the person or entity that receives the information is not a healthcare provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that the office and its employees have a responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I release
The Center for Health and Wellbeing, and employees of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:
3636 Fifth Ave, Suite 300, San Diego, CA 92103

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient.

SIGNATURE

Date: _____

Time: _____am/pm

Print Name: _____

Signature: _____

(Circle one: patient/representative/spouse/financially responsible party)

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