IMPERIAL VALLEY
Family Care
Medical Group

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, understand **Imperial Valley Family Care Medical Group** is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of **Imperial Valley Family Care Medical Group**, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed *(check all that apply)*:

[ ] The patient's entire medical record
(NOTE: This requires an explanation why the entire record may be disclosed)

[ ] The patient's demographic information *(check all that apply)*:
[ ] Name [ ] Address [ ] State/Zip Code only [ ] Telephone
[ ] Age [ ] Gender [ ] Race
[ ] Other: _____

[ ] Medical Data/Information as related to:
[ ] Specific Condition(s): _____
[ ] Specific Professional Service(s): _____
[ ] Specific Medication(s): _____
[ ] Other: _____

[ ] Other: _____
_____

Name(s) or class of person(s) other than current employees or owner(s) authorized by this form to use and disclose the patient's protected health information:
_____

Name)s) or class of person(s) authorized by this form who may use and disclose the patient's protected health information:
_____
_____

Purpose(s) of the information:
_____
_____

[ ] *(Check if applicable)* This authorization is to be used for our own use, and **Imperial Valley Family Care Medical Group** will not condition treatment or payment on this authorization. Moreover, the patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.
[ ] *(Check if applicable)* The patient understands that **Imperial Valley Family Care Medical Group** may receive financial gain as a result of disclosing this information due to _____.
[ ] *(Check if applicable)* This authorization permits **Imperial Valley Family Care Medical Group** to send the protected health information ONLY to this address or fax number:
_____
_____
Any other address or fax number is not permitted by this authorization.

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, **Imperial Valley Family Care Medical Group** must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient account number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

Imperial Valley Family Care Medical Group will accept written revocations of this authorization via:
[ ] Certified U.S. Mail
[ ] Facsimile at this number:_____

ALL revocations must be sent to **Imperial Valley Family Care Medical Group** to the attention of the Privacy Officer, and are not effective until received by the Privacy Officer.

This authorization shall expire on _____. After this date, **Imperial Valley Family Care Medical Group** can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____
Patient's Signature Date

FOR OFFICE USE ONLY
Authorization added to the patient's medical record on _____

Authorization verified by _____on_____

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