

# VISTA COMMUNITY CLINIC

## AUTHORIZATION FOR USE, DISCLOSURE OR REQUEST OF HEALTH INFORMATION

Failure to provide all information requested may invalidate this Authorization.

### USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Other Name(s) used: \_\_\_\_\_

I hereby authorize the use, disclosure or request of my health information as follows:

Vista Community Clinic

Circle One

Person / Organization

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Receive  
From

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_, Zip \_\_\_\_\_

Release  
To

Phone \_\_\_\_\_

Fax \_\_\_\_\_

This Authorization applies to the following information (select *only one* of the following):

- |  |  |
|--|--|
| <input type="checkbox"/> Medical Records   | <input type="checkbox"/> Alcohol Abuse Records   |
| <input type="checkbox"/> Dental Records  | <input type="checkbox"/> Drug Abuse Records      |
| <input type="checkbox"/> Mental Health Records   | <input type="checkbox"/> X-Ray Reports           |
| <input type="checkbox"/> Immunization Records  | <input type="checkbox"/> Lab Reports             |
| <input type="checkbox"/> Consultation (s)  | <input type="checkbox"/> Discharge Summary (ies) |
| <input type="checkbox"/> Acquired Immunodeficiency Syndrome (AIDS), or<br>Test or Infection with Human Immunodeficiency<br>Virus (HIV) Records | <input type="checkbox"/> Other _____             |

This Authorization expires [insert date or event]: \_\_\_\_\_

My health information will be used for the following purposes only: \_\_\_\_\_

(I may inspect or obtain a copy of the health information that I am being asked to use or disclose.)

### YOUR RIGHTS

The requestor of my information may not condition treatment, payment or health care operations on a signed authorization unless

- The authorization is for the provision of research-related treatment
- To enable the Requestor to determine its obligation to pay a claim.
- The purpose of the authorization is to permit the creation of information for the specific purpose of disclosure to a third party.

I may refuse to sign this Authorization or I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: Vista Community Clinic, 1000 Vale Terrace, Vista, CA 92083. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization. I have a right to receive a copy of this authorization.

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_  
(patient/representatives, spouse, financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient: \_\_\_\_\_

Witness: \_\_\_\_\_

*If you have authorized the disclosure of your health information to someone not legally required to keep it confidential, it may be redisclosed and may not be protected. California law prohibits the requestor from making further disclosure of your health information unless the Requestor obtains another authorization from you or unless such disclosure is specifically required or permitted by law.*

**The fee for a copy of your record is \$5.00.**