VISTA COMMUNITY CLINIC

Authorization for Use and/ or Disclosure of Health Information

Completion of this document authorizes the disclosure and/ or use of health information about your health record. Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: ________________________________ Date of Birth: ____________________

Other Name(s) Used: ___________________________ Medical Record #: ________________

Email Address: ____

I authorize the use, disclosure, or request of my health information as follows *(Fill in all blank spaces)*:

Vista Community Clinic	Check One	Person / Organization
Attn: Medical Records 1000 Vale Terrace Drive Vista, CA 92084 Phone: 760-631-5000 ext. 1345 Fax: 760-414-3892 Email: vccrecords@vcc.clinic	❒ **Receive** Records From ❒ **Release** Records To	Name: ______________________ Address: ____________________ City: __________ State: ______ Zip: ______ Phone: _____________________ Fax: _______________________

INFORMATION TO BE RELEASED

The dates of service I am requesting are from: ____________________ to ____________________.

If no date is entered, only the most recent 6 months will be released.

- ❒ Medical Records
- ❒ Dental Records
- ❒ Immunizations
- ❒ Labs
- ❒ Radiology Report(s)
- ❒ Specialist Consultation(s)
- ❒ Other – please be specific: ________________________________

AUTHORIZATION TO RELEASE PROTECTED INFORMATION

I specifically authorize release of the following information:

- ❒ Acquired Immunodeficiency Syndrome (AIDS)/ Human Immunodeficiency Virus (HIV) Testing and Treatment Information
- ❒ Alcohol/ Drug Treatment Information
- ❒ Mental Health Treatment Information

FORMAT REQUESTED

Access your Personal Health Record online at no cost by enrolling into Patient Portal. To sign up, go to www.vcc.clinic and click on the 'Patient Portal' link at the top of the page.

❒ Paper Copy
Time: Takes up to 15 days
Fee: There will be a charge for records requests. An invoice will be sent to you prior to release of records.

❒ Encrypted Electronic Copy
❒ CD ❒ Email to address listed above
Time: Takes 3 days if copy is for self; otherwise up to 15 days
Fee: There will be a charge for sending records in CD format. You will receive an invoice prior to release of records.

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EXPIRATION

This Authorization expires on [date or event]:____

If no date is given, this authorization will expire 12 months from the signature date.

PURPOSE OF REQUESTED USE OR DISCLOSURE

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

MY RIGHTS AS A PATIENT

- I have a right to receive a copy of this Authorization and I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- 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. If I refuse to sign this Authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing. The revocation must be signed by me or by my behalf, and submitted to the following address:

  Vista Community Clinic, 1000 Vale Terrace Drive Vista, CA 92084.
- My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.
- If I have authorized the disclosure of my health information to someone not legally required to keep it confidential, it may be re-disclosed and may not be protected. California law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another Authorization from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE

Patient Signature: ____ Date: _____________

Legal Representative Signature: _____________________________________ Date: _____________

Patient representative, spouse, or financially responsible party.

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

VCC STAFF USE ONLY

Witness/ Reviewer Name (Print): ____________________________________ Date: _____________

This is the name of the person who witnessed and reviewed the form for completeness

Request Processed/ Completed in-clinic by (Initials): _______________________ Date: _____________

If not completed in-clinic, leave blank