VCC

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)*:

Check One:	Person / Organization
❒ To **send records to VCC**: Secure Fax to **(760) 414-3892** or mail to: 1000 Vale Terrace Drive, Vista, CA 92084 P: (760) 631-5000 ext. 4916 Secure E: vccmedicalrecords@vcc.org	Name: _____ Address:_____ City: _____ State: _____ Zip: _____
❒To **request records from VCC**: Secure Fax to (**760) 414-3892** Secure E: vccmedicalrecords@vcc.org	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.

- ❒ Office Visits
- ❒ Dental Records
- ❒ Immunizations
- ❒ Labs
- ❒ Radiology Report(s)
- ❒ Specialist Consultation(s)
- ❒ Other – (please specify, i.e. Hospital, ER, Previous Providers, etc): _____

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

❒Behavioral Health or Mental Health Treatment Information,

FORMAT REQUESTED when requesting records from VCC

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

❒ Encrypted Email ❒ Paper Copy ❒ Secure Fax

EXPIRATION

This Authorization expires on [date or event]:_____

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

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PURPOSE OF REQUESTED USE OR DISCLOSURE

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

- ❒ Moving out of State
- ❒ Insurance Coverage
- ❒ Transfer of Care (please specify):_____
- ❒ Other (please specify):_____

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 <u>not</u> completed in-clinic, leave blank