I hereby authorize:

☐ Palomar Medical Center Escondido ☐ Palomar Medical Center Poway	All requests for copies of Hospital Records are processed at: Palomar Medical Center Escondido **Attention: Medical Records Department** 2185 Citracado Parkway, Escondido, CA 92029 Phone: 760-480-7901 Fax: 760-480-7966
☐ The Villas at Poway	15615 Pomerado Road, Poway CA 92064 858-613-4820
☐ Other: Name of person or facility, which has Information	

To release Protected Health Information (PHI) to:

_____ _____

Name of person or facility to receive health information — Telephone Number

_____

Address: Street Address, City, State and Zip Code

Delivery Method: (Please Choose ONE)	☐ ELECTRONIC WEB ACCESS ☐ MAIL–PAPER ☐ PICK UP-PAPER	☐ REVIEW ☐ MAIL-CD/DVD ☐ PICK UP CD/DVD
	☐ EMAIL SECURE_____ Initial here	☐ EMAIL-UNsecure_____ Initial here
	_____ Email Address – please print clearly	

Information to be Released: Place your **initials** next to each category of information you authorize Release of:

_____ **Entire Records - Multiple visits** (**FOR PAPER RECORDS, $0.25/*PER PAGE CHARGE APPLIES)***
_____ **Emergency Department Visit** (ED Reports, Consultation Reports, Procedure Notes, Radiology Reports, Laboratory Tests)
_____ **Hospital Stay** (History/Physical Exam, Consultation Reports, Operative/Procedure Reports, Discharge Summary, Radiology Reports, Laboratory Tests)
_____ Radiology/Nuclear Medicine Reports
_____ Laboratory Tests
_____ Pathology Reports
_____ Outpatient Rehab
_____ Other/Specify_____

_____ **Psychiatric Records**
_____ **Drug/Alcohol Information**
_____ **HIV Test Results (Human Immunodeficiency Virus)**

Substance Abuse and Addiction Treatment Records (check all that apply)

☐ Assessment/Evaluation ☐ Family participation invitation ☐ Discharge Summary
☐ History and physical exam ☐ Questionnaires ☐ Other, specify:_____
☐ Multidisciplinary notes ☐ Treatment Plan

Pt Name
MR #
Date _____ Age ____
Sex: ☐ M ☐ F
Affix pt name label here

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

PALOMAR HEALTH
A California Public Healthcare District

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE
Dates of Service: From _____ To: _____

Use of Information: The individual or entity identified above is permitted to use my information for the following purposes: **Please initial all that apply.**

_____ Continuing Medical Care _____ Personal Copy _____Legal
_____ Insurance _____ Other (please specify) _____

Expiration Of Authorization:
Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to: Palomar Health, **Attention: Privacy Office,** 120 Craven Road, Suite 224, San Marcos, CA 92078.
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.
Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless specifically required or permitted by law.
I understand I am entitled to receive a copy of this Authorization.
I hereby release my attending physicians and their associates, and the hospital and its employees and agents from any liability from the release of this information.
I agree that a photocopy or faxed copy of this authorization shall be as valid as the original.

By signing below, I acknowledge I have read and understand pages 1 and 2 of this authorization.

Signature:
Signature: _____ Date/Time: _____
(Patient/Legal Representative)

Patient Printed Name: _____ Patient's Date of Birth: _____

Patient's Phone #: _____ Cell Phone #: _____

If signed by other than patient, indicate relationship to patient:_____

Facility Use:

☐ DPOA-HC	☐ Conservatorship	☐ Driver's License #:	☐ Other	FIN:
		_____	_____	_____