AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____ Phone #: _____

Please list all former/other names used: _____

Please complete all fields below. Additional documentation may be required in order to process your request. This authorization is being requested of you to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

AUTHORIZATION OF RELEASE

TrueCare™
Attn: HID
4056 Calle Platino
Oceanside, CA 92065
Fax: 877-279-1995

I hereby authorize **(choose only one):**

☐ **Option 1: TrueCare™ to obtain a copy of records from:**	☐ **Option 2: TrueCare™ to release patient records to:**	☐ **Option 3: TrueCare™ provider to verbally communicate my health information with:**
Name of Facility/Provider/ Person:	Name of Facility/Provider/ Person:	Name of Facility/Provider/ Person:
Address:	Address:	Address:
City/State/Zip Code	City/State/Zip Code	City/State/Zip Code
Phone #:	Phone #:	Phone #:
Fax #:	Fax #:	Fax #:
Preferred Method: ☐ Mail ☐ Fax	Preferred Method: ☐ Pick-up ☐ Mail ☐ Fax	

INFORMATION TO BE RELEASED (Check all that apply)	**For dates of service**: _____ / _____ / _____ to _____ / _____ / _____. Month Day Year Month Day Year If no date is specified, only the previous 6 months will be released. ☐ **General health information**: Problem list, immunizations, progress notes, labs, and radiology results. ☐ **Prenatal records only** **Results/report**: ☐Colonoscopy ☐Dexa Scan ☐Immunizations ☐ **Billing Records** ☐Mammogram ☐Pap Smear ☐ **Other** (Please specify, i.e. hospital, ER, etc...): _____
SENSITIVE INFORMATION	**Sensitive information WILL NOT BE RELEASED unless you tell us by initialing below:** Initial ☐ _____ Mental health treatment information ☐ _____ Psychiatric progress notes ☐ _____ Therapy notes Initial ☐ _____ Labs ☐ _____ HIV test results ☐ _____ Alcohol/drug treatment records

Complete page 2 →

Patient Name: _____ DOB: _____ Phone #: _____

PURPOSE OF REQUEST (Optional)	☐ Specialty Care/Continuity of Care ☐ Changed Primary Care Provider (PCP) ☐ Relocating to another area ☐ Legal ☐ Other _____
PATIENT RIGHTS	• I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I would like to receive a copy of my health information**:** ☐ Yes Initial: _____ • I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: **TrueCare™, 4056 Calle Platino, Oceanside, CA 92065**. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization. • I may be charged for copying my medical and billing records. Fee is $0.25 per page up to $15 per record for patient requests. Any requests for records within the last 2 years of service will be free.
REQUIRED SIGNATURES	**Patient/Legal Guardian/Representative Signature: _____** **Date: _____** This authorization will expire one year from the date the Authorization is signed unless revoked in writing before that date. **Legal Guardian/Representative Name: _____** **Relationship: _____** If signed by someone other than the patient, state relationship and authority to act for the patient.

TRUECARE™ USE ONLY

Print Staff First Last Name: _____ Date: _____ Location: _____

Clinic: Indicate how the request was addressed	**Records to be Released**	**Requesting Outside Records**
	☐ Records given to the patient ☐ Forward to HID to complete request	☐ Faxed request to outside entity, records received ☐ Faxed request to outside entity, records **not** received, HID to follow-up. ☐ Forward request to HID to complete request

For updates on ROI status, check tasks (Task type: Image, Description: Release of Records).