



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
 400 S. Melrose Drive, Suite 200
 Vista, CA 92081
 Fax: 877-279-1995

I hereby authorize TrueCare™ to obtain a copy of records from:

Name of Facility/Provider/ Person: _____

Address: _____

City/State/Zip Code: _____

Phone #: _____

Fax #: _____

Preferred Method:

Mail Fax

INFORMATION TO BE RELEASED

(Check all that apply)

For dates of service: _____ / _____ / _____ to _____ / _____ / _____.
Month Day Year Month Day Year

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:

<p>Initial</p> <p><input type="checkbox"/> _____ Mental health treatment information</p> <p><input type="checkbox"/> _____ Psychiatric progress notes</p> <p><input type="checkbox"/> _____ Alcohol/drug treatment records</p>	<p>Initial</p> <p><input type="checkbox"/> _____ Labs</p> <p><input type="checkbox"/> _____ HIV test results</p>
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Complete page 2 →

Patient Name: _____ DOB: _____ Phone #: _____

PURPOSE OF REQUEST	<input type="checkbox"/> Specialty Care/Continuity of Care <input type="checkbox"/> Relocating to another area <input type="checkbox"/> Other _____ <input type="checkbox"/> Changed Primary Care Provider (PCP) <input type="checkbox"/> Attorney/Legal
PATIENT RIGHTS	<ul style="list-style-type: none"> I may inspect or obtain a copy of the health information that I am being asked to allow for use or disclosure. I would like to receive a copy of my health information: <input type="checkbox"/> Yes Initial: _____ I may revoke this authorization at any time prior to the expiration date, but I must do so in writing and submit it to the following address: TrueCare™, 400 S. Melrose Drive, Suite 200, Vista, CA 92081. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.
REQUIRED SIGNATURES	<p>Patient/Legal Guardian/Representative Signature: _____</p> <p>Date: _____</p> <p>This authorization will expire one year from the date the Authorization is signed unless revoked in writing before that date.</p> <p>Legal Guardian/Representative Name: _____</p> <p>Relationship: _____</p> <p>If signed by someone other than the patient, state relationship and authority to act for the patient.</p>

TRUECARE™ USE ONLY

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

Clinic: Indicate how the request was addressed	<p>Requesting Outside Records</p> <input type="checkbox"/> Faxed request to outside entity, records received. <input type="checkbox"/> Faxed request to outside entity, records not received, HID to follow-up. <input type="checkbox"/> Forward to HID to complete request.
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For updates on ROI status, check tasks (Task type: Image, Description: Release of Records).