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:** Initial Initial ☐ _____ Mental health treatment information ☐ _____ Labs ☐ _____ Psychiatric progress notes ☐ _____ HIV test results ☐ _____ Alcohol/drug treatment records

Complete page 2 →

Patient Name: _____ DOB: _____ Phone #: _____

PURPOSE OF REQUEST	☐ Specialty Care/Continuity of Care ☐ Changed Primary Care Provider (PCP) ☐ Relocating to another area ☐ Attorney/Legal ☐ Other _____
PATIENT RIGHTS	• 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**:** ☐ 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 920**81. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.
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	**Requesting Outside Records** ☐ Faxed request to outside entity, records received. ☐ Faxed request to outside entity, records not received, HID to follow-up. ☐ Forward to HID to complete request.

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