PATIENT ACCESS REQUEST FOR HEALTH INFORMATION FORM

TrueCare recognizes a patient's right of access under HIPAA and the 21st Century CURES Act Information Blocking Rules. This form is for use when such authorization is required and complies with HIPAA Privacy Standards. All sections of this authorization must be completely filled out before TrueCare is permitted to disclose your protected health information.

First Name:	**Middle Initial:**	**Last Name:**	
Name at Time of Treatment (if different than above):		**Date of Birth (MM/DD/YYYY):**	
Phone:		**Email Address:**	
Street Address:			
City:		**State:**	**Zip Code:**

RETURN COMPLETED FORM TO	**TrueCare** **Attention: Health Information Department** **400 S. Melrose Drive, Suite 200** **Vista, CA 92081** **Phone: (760) 736-6717** | **ROI Department Fax: (877) 279-1995** | **Email: Fax_HID@truecare.org**
INFORMATION TO BE RELEASED (Check all that apply) ***If no dates of service are specified, only the previous 6 months of health information will be released.***	**Dates of service:** _____/_____/_____ to _____/_____/_____ Month Day Year Month Day Year ☐ **General health information**: Problem list, visit/progress notes, visit summary, dental notes, procedure reports, medication lists. ☐Other (please specify): _____ **Results/report**: ☐Colonoscopy ☐DEXA Scan ☐Immunizations ☐Mammogram ☐Pap Smear ☐Radiology Report(s) ☐Lab/Pathology Results ☐Other (please specify): _____ ☐ **Reproductive Health Care** ☐**Alcohol/Drug Information** ☐**HIV related Information** ☐ **Mental Health** ☐ **Billing Records** ☐**Other** (please specify): _____
PURPOSE OF REQUEST	☐ Continuity of Care/Specialty Care ☐ Primary Care Provider change (PCP) ☐ Attorney/Legal ☐ Other (please specify): _____
DELIVERY METHOD (Check **ONE** option)	☐ Mailed ☐ Pick Up at TrueCare Location (please specify): _____ ☐ Secure Email: _____ ☐ MyChart ☐ USB/Flash drive ☐ Other/Third Party App (please specify): _____
RECIPIENT Where do you want your information sent?	**Self** ☐ **Parent/Guardian/Legal Representative** ☐ **Facility/Provider** ☐ **Other:** _____ **Name:** | **Phone:** **Address:** | **Fax:** **City/State/Zip:** | **Email:**
PATIENT RIGHTS	TrueCare may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization. A copy of the original authorization is valid. You have the right to receive a copy of this completed authorization. **REVOCATION:** You or your personal representative may cancel this authorization for future releases by submitting a written request to **TrueCare, 400 S. Melrose Drive, Suite 200, Vista, CA 92081**. Your cancellation will not affect information that was released prior to receipt of the written request. **DURATION:** Authorization shall remain in effect for one year from the date of signature below. **REDISCLOSURE:** Once this information is released, it may not be protected under federal privacy law (HIPAA). State or other federal law may require the recipient to obtain your authorization before further disclosure.
REQUIRED SIGNATURES	**Name of Patient or Personal/Legal Representative (Please Print):** | **Relationship to Patient:** **Signature of Patient or Personal/Legal Representative:** | **Date Signed:**
For internal use by TrueCare ONLY	**MRN:** | **TrueCare Location:** | **Date Received:** **Received By:**