RECORD REQUEST

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

EXPLANATION: This authorization is necessary for us to comply with state and federal laws pertaining to the use or disclosure of PHI, protected health information, about the patient identified below. Please provide all requested information.

Name of patient: _____ Date of birth: _____

Other Names: _____

1. **PERSONS AUTHORIZED TO DISCLOSURE PHI**: I authorize the following person(s) to disclose the health information about the patient listed above. (State name, address & phone number of physician and/or institution records are required from):

   _____
   _____
   _____

2. **DESCRIPTION OF INFORMATION**: This authorization permits the use and/or disclosure of the following information about the patient. (Check all applicable selection)

   ____ All health information pertaining to any medical history, physical condition and treatment received for the date from: _____ to _____ or only the following records or types of health information checked below:

   ☐ Operative Report ☐ Emergency Room Records ☐ Consultation ☐ Pathology Reports
   ☐ Ultrasound Reports ☐ Lab Reports ☐ X-Ray Results

   ☐ All health information relating to the following date of treatment _____ and type of treatment: _____

3. **AUTHORIZED USERS AND RECIPIENTS**: I hereby authorize the following person or facility to receive and/or use the health information checked above. (State name, address & phone number of physician and/or institution records are required from)

UNICARE COMMUNITY HEALTH CENTER:

☐ 437 N. Euclid Ave. **Ontario, CA** 91762 –Tel (909) 988-2555 –Fax (909) 988-4447
☐ 1501 E. Holt Ave. Ste. A, **Pomona, CA** 91767 –Tel (909) 623-3600 –Fax (909) 623-3383
☐ 507 S. Mt. Vernon Ave. Ste. G, **San Bernardino, CA** 92410 –Tel (909) 884-6700 –Fax (909) 884-6705
☐ 16127 Foothill Blvd. **Fontana, CA** 92335 –Tel (909) 347-0700 –Fax (909) 355-3447
☐ 308 N. La Cadena Dr. **Colton, CA** 92324 –Tel (909) 321-4700 –Fax (909) 824-2887
☐ 2409 N. Broadway, **Los Angeles, CA** 90031 –Tel (323) 225-8038 –Fax (323) 225-2106

4. **PURPOSES**: I hereby authorize the information checked above to be used and/or disclosed for the following purposes: (Check all application selection)

   ____ Requested by patient or personal representative.
   ____ Others:
   _____
   _____

5. **RIGHT OF REVOCATION**: I understand that I have the right to revoke this authorization at any time, provided that my revocation is in writing. The revocation will be effective upon its receipt by *Unicare Community Health Center*, but will not affect records that already have been acted upon when the authorization was in effect.
6. **REDISCLOSURE**: I understand that if the recipient of my information listed above is not a healthcare provider, a health plan or healthcare clearinghouse or not an entity required to comply with federal or state health privacy regulations, my health information may be further disclosed by such recipient and my information may no longer be protected by state and federal laws.
7. **CALIFORNIA/ARIZONA RESTRICTION**: I understand that a recipient of medical information in California or Arizona may not further disclose medical information about me (patient) unless a new authorization from is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.
8. **RIGHT TO REFUSE TO SIGN**: I understand that I do not have to sign this authorization form and that my failure to sign will not affect my ability to obtain treatment.
9. **AUTHOMATIC ONE-YEAR DURATION**: This authorization will automatically expire after one (1) year from date of execution unless a different date is set: _____
10. **COPY RECEIVED**: I acknowledge receipt of a signed copy of this authorization form _____ (initial)

_____ _____

Signature of patient (or personal representative) **Date**

_____ _____

Print name of patient (or personal representative) **Relationship to patient**

Address: _____ **Phone Number: _____**

_____