Central Coast Med Plus

Dignity Health
Pacific Central Coast
Health Centers

Authorization for Use and Disclosure of Medical Information

PATIENT INFORMATION

Patient Name: _____

Patient Date of Birth: _____Phone:_____

Patient's Address:_____

I hereby authorize **Central Coast Med Plus** to release my/or the patient's medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax or other electronic methods.

This authorization is for:

___ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

___ limited to the following medical information LABS X-RAY ❑CONSULTS

OTHER_____

I also consent to the **specific release** of the following records:

Drug/Alcohol/Substance Abuse	____(initial)	HIV Diagnosis/Treatment	____(initial)
Psychiatric/Mental Health	____(initial)	Genetic Information	____(initial)
Tests for Antibodies to HIV	____(initial)	Self-Paid visits	____(initial)

Release To:_____

Name

_____

Address

_____ _____

Phone Fax

Duration: This authorization shall be effective immediately and remain in effect for 120 days from date signed.

Restrictions: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Patient or legal/personal representative Relationship if other than patient

_____ _____

Printed Name of Patient or legal/personal representative Date

_____ _____

Witness Signature Witness Name (Print)

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