CERTIFIED
INFORMATION MANAGEMENT
Securing Your Information

Authorization for Release of Medical Records

Patient Name: _____ SSN: _____
Date of Birth: _____ Telephone #: _____
Address: _____
Date(s) of Treatment requested: From: _____ To: _____
I request access as the: ❒ Patient ❒ Parent ❒Conservator/Executor

Records requested: Please check appropriate boxes

☐ **All Records – "Any and All" - Package A**

☐ **Pertinent Records - Package B**

❒ Discharge Summary	❒ Laboratory Tests	❒ Pathology Reports
❒ History and Physical	❒ Radiology Reports	❒ ER Report
❒ Consultation Reports	❒ Cardiology Reports	❒ Operation Reports
❒ Face Sheet		

By applying a check next to a category of highly confidential information listed below and **signing on the appropriate line after the checked box**, I specifically authorize the disclosure indicated next to my signature:
❒ Mental Illness: _____
❒ HIV/AIDS Testing, Diagnosis, or Treatment: _____
❒ Substance Abuse, Prevention or Treatment: _____

RECIPIENT: Name of person or class of persons to whom Certified Information Management may disclose my health information:

PLEASE CIRCLE ONE

Attorney Doctor Insurance Self Other:_____

Name and Address to where my health information should be released:

_____
_____
_____

I would prefer to: ❒ pick-up or ❒ have the requested information mailed.

Right to Copy: I have a right to receive a copy of the Authorization after I sign it.

Re-Disclosure Statement: I understand that once Certified Information Management discloses my health information to the recipient, Certified Information Management cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable law governing the use and disclosure of my health information.

Duration: This authorization will expire 12 months from the date signed.

Purpose: I authorize Certified Information Management to use or disclose my health information (including the highly confidential I selected above, if any) during the term of this Authorization for the following specific purpose(s):
Note: **"at the request of the Patient"** is sufficient if the Patient is initiating this Authorization: _____

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize San Diego Center for GYN Oncology to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient Signature of Personal Representative

Description of Authority: _____ Date: _____

Office Use Only

Release of records: ❒ Approved ❒ Denied
Reason for denial: _____
Signature: _____ Date: _____

Date records reviewed or inspected: _____
HIM Employee: _____

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