Western Sierra Medical Clinic
a california health+ center

Authorization to Disclose Health Information

www.wsmcmed.org

PATIENT DATA

Full Name (Please Print): ____ Date of Birth: _________________________

AKA: ____ SSN: ___________-__________-___________

Address: ____ Home Phone: _________________________

City, State, Zip: ____ Work Phone: _________________________

AUTHORIZATION - INFORMATION TO BE RELEASED *FROM*:

Facility/Physician: ____ Patient ID: ____________________________

Address: ____ Medical Records #: ____________________

City, State, Zip: ____ Account #: _____________________________

Phone: ____________________________ Fax: __________________________ HIPAA Log: Yes ☐ No ☐

INFORMATION TO BE DISCLOSED *TO*:

Western Sierra Medical Clinic
844 Old Tunnel Road
Grass Valley, CA 95945
Phone: 530-274-9762
Fax: 530-273-7659

PURPOSE OF RELEASE:

☐ Continuing Care
☐ Consultation
☐ Second Opinion
☐ Patient's Request
☐ Other

This authorization is valid for six (6) months from the date of consent or expires on the following specified date, event, or condition: ____. I understand that by completing this request form I will be subject to the new patient review process that will determine if I will be accepted as a patient at this clinic.

I AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION:

			All Records
☐ Office Medical Records	From (date) _______________	to (date) _______________	☐
☐ Imaging Records (X-rays, etc)	From (date) _______________	to (date) _______________	☐
☐ Lab / Pathology Records	From (date) _______________	to (date) _______________	☐
☐ Consultation Reports	From (date) _______________	to (date) _______________	☐
☐ Other: ________________________	From (date) _______________	to (date) _______________	☐

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CONTINUED

SPECIAL CONSENT / CONDITIONS

The following records require the patient's signature and date they will be released under the same conditions as outlined above:

☐ Psychiatric Records
☐ Alcohol / Drug Abuse Records
☐ STD / AIDS / HIV Records

______________________________ ______________________________ ____________
Patient or Legal Representative **Relationship (if not patient)** **Date**

MEDICAL RECORD COPYING SERVICES

The medical records you requested are copied by EGF Business Services. EGF is under agreement with Miners to copy all medical records when an authorized release is furnished.

If you wish a copy for yourself of the past two-year's records, there will be a maximum charge of $15.00. If you require a copy of more than two years, there will be no maximum fee and EGF Business Services will contact you for this service.

The photocopies have been made from the Doctor's original medical records. Federal and State laws protect the confidentiality of the records.

If you should have any questions regarding the records, please contact medical records at 530-274-9762.

SIGNATURE

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that a revocation is not effective to the extent that the provider has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to electronic disclosures by the recipient and may no longer be protected by federal or state law. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I further understand there may be a fee associated with my request for the release of information as governed by the California Health and Safety Code #123110.

______________________________ ______________________________ ____________
Patient or Legal Representative **Relationship (if not patient)** **Date**