Sutter Health
Palo Alto Medical Foundation

Patient label

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Birth Date: ___ / ___ / _____

Date(s) of Service: Any and All Dates _____ Phone Number: _____

I hereby authorize:
Palo Alto Medical Foundation 795 El Camino Real Palo Alto, CA 94301
Name Address City State Zip

To release my health information to (Recipient): c/o Compex Legal Services
325 Maple Ave Torrance, CA 90503
Name Address City State Zip

This authorization applies to the following information:

[✘] Discharge Summary
[✘] History & Physical
[✘] Consultation
[✘] Operative Report
[✘] Inpatient Progress Notes
[✘] Emergency Record
[✘] Laboratory Test(s)
[✘] Radiology Report(s)
[✘] Other: Billing Records
[ ] Pathology Report(s)
[✘] EKG Report(s)
[✘] Echocardiogram Report(s)
[✘] Immunization Records
[✘] Same Day Surgery Record
[✘] Complete Medical Record
[✘] Outpatient Clinic Records
[✘] Radiology Images (x-rays)

I specifically authorize release of the following information:

[ ] HIV test results ___ (initial)
[ ] Mental Health ___ (initial)
[ ] Substance abuse ___ (initial)
[ ] Genetic testing ___ (initial)

Purpose of requested use or disclosure: [ ] Patient Request; OR [✘] Other:
Evaluation of a claim

Form and format of information:

[✘] Paper Copy [✘] CD [ ] USB Drive [ ] Available for inspection only
[ ] E-mailed (encrypted) (Note: If you would like us to send information over email unencrypted, this increases the risk that the information could be read by an unauthorized third party.)
[ ] Other (must be agreed upon by patient and provider): _____

Information will be: [✘] Mailed [✘] Picked-Up

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EXPIRATION: This authorization shall become effective immediately and shall remain in effect for one year from the date signed unless a different date is specified here:

_____

RESTRICTIONS: California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

YOUR RIGHTS:

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address:
  Compex Legal Services 325 Maple Ave Torrance, CA 90503
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have a right to receive a copy of this authorization (required if authorization is requested for the provider's use or disclosure of health information).
- I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.

If this box [ ] is checked the facility listed above will receive compensation for the use or disclosure of my health information.

SIGNATURE: _____ Date: _____ Time: _____
(Patient/Legal Representative)

If signed by other than patient, print name and relationship:

_____ _____
Name Relationship

When completed, check the box below for the PAMF Division where your doctor is located and send the form to the corresponding ACTA Medical Services Inc.

☐ **PAMF Camino Division** 701 E. El Camino Real Mountain View, CA 94040 Phone: 408-523-3267 Fax: 408-524-5034	☐ **PAMF Mills-Peninsula Division** C/O PAMF Camino HIM 701 E. El Camino Real Mountain View, CA 94040 Phone: 408-523-3267 Fax: 408-524-5034	☐ **PAMF Alameda & Palo Alto Division** 795 El Camino Real Palo Alto, CA 94301 Phone: 650-853-4745 Fax: 650-853-6093	☐ **PAMF Santa Cruz Division** 2880 Soquel Ave., Ste. 1 Santa Cruz, CA 95062 Phone: 831-458-5520 Fax: 831-479-6636