I hereby authorize:

☒ Palomar Medical Center ☒ Palomar Health Downtown Campus ☒ Pomerado Hospital	All requests for copies of Hospital Records are processed at: Palomar Health **Attention: Medical Records Department** 2227 Enterprise St. Escondido, CA 92029 Phone: 760-480-7901 Fax: 760-480-7966
☒ Villa Pomerado	15615 Pomerado Road, Poway CA 92064 858-613-4545
☐ Other: Name of person or facility, which has Information	

To release Protected Health Information (PHI) to:

Name of person or facility to receive health information _____ Telephone Number _____

c/o Compex Legal Services 325 Maple Ave Torrance, CA 90503

Address: Street Address, City, State and Zip Code

Delivery Method:	☒ Mail	☒ PICK-UP

Information to be Released: Place your **initials** next to each category of information you authorize Release of: Initials Required below for each type of record to be released

_____ Emergency Department Reports
_____ Discharge Summary
_____ History/Physical Exam
_____ Operative/Procedure Reports
_____ Radiology/Nuclear Medicine Reports
_____ **HIV Test Results (Human Immunodeficiency Virus)**
_____ **Psychiatric Records**
_____ Consultation Reports
_____ Laboratory Tests
_____ Pathology Reports
_____ Drug/Alcohol Information
_____ Genetic Testing
_____ Outpatient Rehab
_____ Other/Specify_____

_____ Entire Records- Multiple visits (***A PER PAGE CHARGE APPLIES $.25/page)***
_____ Electronic Documents

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE

Dates of Service: From Any To: All

Use of Information: The individual or entity identified above is permitted to use my information for the following purposes: **Please initial all that apply.** Initials required below for the purpose of disclosure

_____ Continuing Medical Care _____ Personal Copy _____Legal
_____ Insurance _____ Other (please specify) _____

Expiration Date:

☒ 3 months from date of signature below or _____ (Date)
☐ I authorize disclosure of my protected health information until the designated expiration as noted above, or revocation, whichever occurs first.

Pt Name
MR #
Date_____ Age _____
Sex: ☐ M ☐ F
Affix pt name label here

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

PALOMAR HEALTH
A CALIFORNIA HEALTH CARE DISTRICT

* 8 7 0 0 - 9 0 5 9 *

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to: Palomar Health, **Attention: Privacy Office,** 2227 Enterprise St. Escondido, CA 92029.
My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless specifically required or permitted by law.
I understand I am entitled to receive a copy of this Authorization.
I hereby release my attending physicians and their associates, and the hospital and its employees and agents from any liability from the release of this information.
I agree that a photocopy or faxed copy of this authorization shall be as valid as the original.

✘ **Signature:**
Signature: _____ ✘ Date/Time: _____
(Patient/Legal Representative)

Patient Printed Name: _____ Patient's Date of Birth: _____

Patient's Phone #: _____ Cell Phone #: _____

If signed by other than patient, indicate relationship to patient:_____

Facility Use:

☐ DPOA-HC	☐ Conservatorship	☐ Driver's License #: _____	☐ Other _____	FIN: _____