ACC
ALTERNATIVE CARE CLINICS

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Roger A. Barnes, MD
Keith R. Wresch, MD

Name: _____ Date of Birth: ____/____/_____
Last First MI MM/DD/YYYY

Medical Record #: _____ SS#: ____-____-_____ Previous Names Used: _____

Current Phone #: _____ Alternate Phone #: _____

I authorize:

_____
NAME OF PERSON/TITLE OR FACILITY WHICH HAS YOUR HEALTH INFORMATION

_____
STREET ADDRESS

_____
CITY **STATE** **ZIP**

PHONE:_____ **FAX:**_____

To release health information to:

(PERSON OR FACILITY TO RECEIVE HEALTH INFORMATION)

ALTERNATIVE CARE CLINICS
MEDICAL RECORDS
4452 PARK BLVD. SUITE 314
SAN DIEGO, CA 92116
PHONE: 866.420.7215 FAX: 619.291.7217

THIS AUTHORIZATION APPLIES TO THE FOLLOWING INFORMATION:

☐ **Imaging Reports** ☐ **Discharge Summary** ☐ **Progress Notes** ☐ **Labs** ☐ **Reports** ☐ **Treatment Dates:** _____

☐ **Records pertaining to:** _____

The information may be disclosed and used by Alternative Care Clinics for the purpose of obtaining the medical history of this patient.

I UNDERSTAND THAT BY SIGNING THIS AUTHORIZATION:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I understand that I may revoke this authorization in writing at any time (see ACC Notice of Privacy practices for instructions), except to the extent that action has already been taken. Unless otherwise noted, this authorization will expire *one year* from the date of my signature.
- I understand that the information in my health record may include information relating to Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol or any drug (substance) abuse and I give permission for these things to be included in the records send to me.
- I understand if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand I have a right to receive a copy of this authorization.
- I understand that I am signing this authorization voluntarily and that treatment, payment, or eligibility for my benefits will not be affected if I do not sign this authorization.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT

Patient Signature:_____ Date:____/____/_____

A COPY OF THIS AUTHORIZATION IS VALID AS AN ORIGINAL