COASTAL VISION MEDICAL GROUP
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
FORM F2

Patient Identification

Printed Name: _____ Date of Birth:_____

Address: _____

Telephone: _____ Social Security #:_____

Information To Be Released

Please check type of information to be released:

- ☐ Medical Record
- ☐ Billing Record
- ☐ Other

Identify date(s) of service of records to be released: _____

Purpose of Use or Disclosure

☐ **Describe Purpose:** _____

☐ **At Request of the Individual (Check here if patient is requesting the release and does not want to provide the purpose)**

Person(s) Authorized to Receive Information

Name & Organization:_____

Address: _____

How May We Deliver Your Information? ☐ **Mail** ☐ **Email:** _____ ☐ **Fax #:** _____ ☐ **Pick Up**

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

To the extent my medical/billing record contains information about drug and/or alcohol abuse, psychiatric care, sexually transmitted diseases, Hepatitis B & C testing, and/or other sensitive information, I agree to the release of this information. ☐ **Yes** ☐ **No**

To the extent my medical or billing record contains information about HIV/AIDS (Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to the release of this information. ☐ **Yes** ☐ **No**

Revocation/Expiration of Authorization

I understand that I have the right to revoke this Authorization at any time by submitting a notice in writing to the Facility Privacy Officer at *293 S. Main Street Suite 100 Orange, CA 92868* and that the revocation will be effective except to the extent that action has already been taken in reliance on this Authorization. I also understand that even if I revoke this Authorization, Facility would be permitted to use and disclose PHI created before the revocation as necessary to maintain the integrity of a research study.

Unless revoked, this Authorization will expire:

☐ On the following date or event: _____

☐ **At the end of the research study**

☐ No expiration date (Can be checked only if Authorization is for use and disclosure of PHI for research)

Re-disclosure

I understand that the information disclosed by this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or state privacy requirements. Facility, its affiliates, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I do not have to sign this Authorization and that my treatment or payment for services will not be denied if I do not sign this Authorization.

PLEASE ATTACH A COPY OF YOUR DRIVER'S LICENSE OR OTHER FORM OF IDENTIFICATION TO THIS FORM

I hereby authorize Facility to use and/or disclose the protected health information as specified above. I understand that I will be charged a $25 administrative fee.

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Print Name of Patient or Personal Representative | Relationship of Personal Representative to Patient (if applicable)

For Completion by the Facility:
Facility or its affiliates is receiving compensation/payment from a third party for use or disclosure of PHI ☐ **Yes** ☐ **No**

Identity of Patient Verified via**:** ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other, specify**_____
Verified by: _____