BEAVER
MEDICAL GROUP, L.P.

AUTHORIZATION TO RECEIVE OR RELEASE MEDICAL INFORMATION

I hereby authorize Beaver Medical Group to ***disclose*** or ***receive*** the following information from the health records of the patient listed below:

PRINT CLEARLY:

SECTION A PATIENT DATA

Patient Name:	SSN:
Phone #:	Date of Birth:

SECTION B RELEASE FROM / TO

Release Information To:	Receive Information From:
Person/Organization:	Person/Organization:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone #: Fax#:	Phone #: Fax#:

SECTION C RELEASE DATA

Purpose of Disclosure: ☐ Personal Access ☐ Continued Care ☐ Other (Describe)

_____

A separate authorization is required to authorize the disclosure or use of psychotherapy notes and HIV test results.

The type of records and the dates of service to be released or disclosed is as follows (✓) check all that apply:

- ☐ Entire record (***including*** Alcohol/drug treatment information)
- ☐ Entire record (***excluding*** Alcohol/drug treatment information)
- ☐ Billing information ☐ Problem list
- ☐ Medication list ☐ Immunization records
- ☐ Laboratory results ☐ X-ray reports
- ☐ Mental health records (excluding psychotherapy notes)
- ☐ Other diagnostic (specify) _____
- ☐ Other _____
- ☐ Limitation of release _____

Date(s) of Service _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

SECTION D
DURATION

EXPIRATION

This authorization will automatically expire six months from the date of execution unless otherwise noted: _____

SECTION E
AUTHORIZATION

YOUR RIGHTS

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information to be used or disclosed, as provided by 45 CFR 164.508(d)(1), (e)(2).

I have a right to receive a copy of this authorization.

I may revoke this authorization at any time, but I must do so in writing and submit it to: **Beaver Medical Group, Medical Records Department, 2 W. Fern Avenue, Redlands, CA 92373**. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I understand that information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPPA). The recipient of this information is requested not to re-disclose this information without my authorization for disclosure. **Beaver Medical Group**, its employees, officers, and physicians are hereby released from any legal responsibility or liability for improper re-disclosure of the above information to the extent indicated and authorized herein.

A copy or photocopy of this authorization will serve the same validity as though an original had been presented.

_____

Signature of Patient or Legal Representative

_____ _____

Print Name ***Relationship***

_____

Address/State/Zip (if other than patient)

_____ _____

Phone # (if other than patient) ***Date Signed***

_____ _____

Signature of Witness ***Date***

SECTION F
OFFICE USE ONLY

Authorization Received by: _____ Date: _____

Patient/Representative Identification: _____ Verified by: _____

A copy of this authorization was offered/received by the patient.

Chart Location (✓): ☐ Redlands ☐ Highland ☐ Yucaipa ☐ Banning ☐ Colton
☐ Terracina-Peds ☐ Terracina -PT ☐ Terracina-Ortho