PATHWAY HEALTHCARE

AUTHORIZATION REQUEST
FOR
RELEASE/DISCLOSURE
OF INFORMATION

190 S Oak Ave, Bldg 2 Suite 1
Oakdale CA 95361
Phone (209) 848-8410
Fax (209) 848-0732

☐ **Obtain from: (other to Pathway Healthcare) or**

☐ **Release to: (Pathway Healthcare to Other)**

Name:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____Fax:_____

Patient Name:_____Date of Birth:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____

Purpose of the requested use or disclosure:_____

The health information described herein shall be obtained/released to/from:

☐ Patient ☐ Hospital ☐ Insurance Company ☐ Attorney ☐ Physician

☐ Other (specify):_____

Description of information to be released: (check all that apply)

☐ All medical records (Clinical Notes, Medication, Treatment, Procedures, Labs)

☐ Radiology records (X-Rays, Ultrasounds, CT Scans, MRI's, Mammography, Etc.)

☐ Specific medical records:_____

☐ Other (describe):_____

☐ STD/HIV Records _____ (initial)

☐ Behavioral Health _____ (initial)

☐ Substance Abuse _____ (initial)

☐ Psychotherapy _____ (initial)

Date(s) of service (if known):_____

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: _____

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Patient Name:_____Date of Birth:_____

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or health care provider, the released information may no longer be protected by federal confidentially law (HIPAA). However, California law prohibits the person receiving your health information from making further disclosure of it unless another authorization for such disclosure is obtained from you or unless such disclosure is specifically required or permitted by law.

I further understand that I may revoke this authorization at any time by notifying Pathway Healthcare in writing. I also understand that the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

I understand that I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.

I understand that I have a right to receive a copy of this authorization

I understand that I may inspect and obtain a copy of the health information of which I am authorizing the use or disclosure of my health information. Inspection will be available within 5 days excluding holidays/weekends and copies will be available within 15 calendar days from the date of receipt of the request. I further understand that if I am requesting a copy for myself, I will be charge $0.25 per page.

X_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed name of Patient's Representative

_____
Relationship to Patient ["Next friend" not an acceptable status.] or Legal Authority (attach supporting documentation)