SPRUCE MULTISPECIALTY GROUP

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

NAME: _____ DOB: _____SSN:_____

Information to be released to: _____
_____ Ph# _____
_____ Fax# _____

Information to be released from: _____
_____ Ph# _____
_____ Fax# _____

Information to be used for:

_____ Continued care to another physician _____ Personal use _____ Other

All allowable fees for copies must be paid prior to records being sent

Send the Following:

_____ Progress notes _____ Lab Reports _____ X-Ray reports _____ Cardiac Workup
_____ Other: _____

For Date of Treatment _____ to _____ or (circle if applicable) **Full Records**

I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt. I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

This authorization is effective for six months from the signed date.
I understand that I have the right to receive a copy of this authorization.

Signed:_____ Date: _____

Printed Name: _____

If not signed by the patient, please indicate relationship:
_____ Parent or guardian of minor patient (to the extent minor could not have consented to the care)
_____ Guardian or conservator of an incompetent patient
_____ Beneficiary or personal representative of deceased patient

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.