VALLEY INTERNAL VIP PHYSICIANS

Authorization for Use/Disclosure of Health Information

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

It is the policy of this medical practice that we will adopt, maintain, and comply with our Notice of Privacy Practices, which shall be consistent with HIPAA and California Law.

Authorization: I hereby authorize _____
(Enter name of physician or healthcare facility from whom you are requesting records.)

to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records (including those from my other healthcare providers that the above named healthcare provider may hold), by means of mail, fax, or other electronic methods to:

Valley Internal Physicians
24680 Jefferson Avenue, Suite A
Murrieta, CA 92562
Phone: (951) 677-2252
Fax: (888) 379-5709
Secure e-mail: info@VIPMurrieta.com

The medical information/records will be used for the following purpose: _____

This authorization is:
- ❒ Limited to the following medical information: _____
- ❒ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV diagnosis/treatment)

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse	_____ (initial)	HIV Diagnosis/Treatment	_____ (initial)
Psychiatric/Mental Health	_____ (initial)	Genetic Information	_____ (initial)
Tests for Antibodies to HIV	_____ (initial)		

Duration: This authorization shall be effective immediately and remain in effect for one year from the date shown below.

Restrictions: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

Signature of patient *or legal representative*	Relationship *if other than patient*
Patient's Name (PRINT)	Date
Patient's Social Security Number	Patient's Date of Birth
Witness Name	Witness Signature