MPG
THE MEDICAL PARTNERS GROUP

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize: _____
Name of person or facility which has information

to release health information to: _____
Name of person or facility to receive health information

_____
Street Address City State Zip Code

□ **Check this box to authorize exchange between the persons/organizations listed above.**

The purpose of this release is for (check one or more):

☐ Continuity of care or discharge planning ☐ Billing and payment of bill

☐ At the request of the patient/patient representative ☐Other (state reason): _____

Please specify the health information you authorize to be released and check all services that apply:

☐ **All Medical Records** ☐ Clinic or Office Visits ☐ Radiology Images
☐ Emergency Room Visits ☐ Entire Hospital Record ☐ Laboratory & Pathology Reports
☐ Immunization Records ☐ (OB)GYN Records

☐ Other Records (not listed above, please specify type): _____ _____

Delivery Method (please select one): ☐ Mail ☐ Pick-up ☐ Online Portal (Medical Records Only)

The following information will not be released unless you specifically authorize it. Please mark box(es) below accordingly:

☐ Information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).
☐ Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, et seq.)
☐ Release of HIV/AIDS test results (Health and Safety Code §120980(g)).
☐ Release of genetic testing information (Health and Safety Code §124980(j)).

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event).
If no date is indicated, the Authorization will *expire 12 months after the date of my signing this form*.

_____ _____

Print Name Signature

_____ _____

Date Time Relationship to Patient
(Parent, Guardian, Conservator, Patient Representative)

NOTICE The Medical Partners Group (TMPG) is required by law to keep your PHI (protected health information) confidential. If you have authorized the disclosure of your PHI someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.