5712 Pirrone Road
Salida, CA 95368
Phone (209) 543-9299
E-Fax (209) 545-9432

****If the report is over 10 pages E-Fax is recommended****

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Information

Patient Name:	Date of Birth:
Address, City, State, Zip:	
Patient Phone:	Email:

Where are you requesting records from?

Facility Name:	
Address, City, State, Zip:	
Phone:	Fax:

Purpose of Requested Use or Disclosure

To aid and facilitate my child's pre-operative clearance. This information is required for medical evaluation for determining the patient's medical condition and the feasibility of surgery and general anesthesia. My child will be undergoing general anesthesia for dental surgery and the disclosure of information authorized herein is required for that purpose only.

❑ Transfer of Care ❑ Per my Request ❑ Other: ______________

Type of Access Requested

❑ Paper ❑ Electronic (i.e.,CD) ❑ Inspection Only

Information Disclosure

Approximate date range: Start: ________________ to End: ___________________

❑ Health and Physical
❑ Lab Test Results: ________________
❑ Hospital Records
❑ Operative Reports/Procedure Notes
❑ Radiology Reports
❑ Sleep Study
❑ Specialist Report: _______________
❑ Other: ________________________

Indicate specific records needed to help respond quickly. (i.e., related to a condition,specific lab tests, all records,etc.)

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Do we have permission to receive the following protected information? Please check all that apply below:

❑ HIV Test Results
❑ Mental Health Records
❑ Substance Use/Drug Abuse Records
❑ Genetic Testing Results

Delivery Method of Records

❑ Fax or E-Fax
❑ Email (referral@salidasurgerycenter.com)
❑ Paper by Mail
❑ Other: _________________

Expiration Date

This authorization shall become effective immediately and remain in effect for one (1) year from the date signed below unless specified here: __________________

Your Rights Under the Law

◆I understand I have the right to refuse to sign this form. I also understand by not signing, may have negative consequences and services may not be provided.

◆I may revoke this authorization at any time. My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.My revocation must be in writing, signed by me or on my behalf, and mailed:
Attn: Medical Records Department, 5712 Pirrone Road, Salida, CA 95368

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

◆I may inspect and obtain copy of my health information for which I am authorizing the use or disclosure of my health information. Copies will be available in 48 hrs unless it is Behavioral Health Records which can take up to 15 days.

◆The location(s) listed above will not receive compensation for the use or disclosure of my health information.

◆I understand that California law prohibits the recipients of my health information from making further disclosure of my health information unless the recipient obtains another authorization from me or unless the disclosure is required or permitted by law. The protection does not extend to recipients outside the state of California.

SIGNATURE AND DATE (As Required by Law)

SIGNATURE: _______________________________ Date/Time: _______________

*If signed by someone other than patient, print name and specify relationship to patient:
Name: ________________________________ Relationship: ________________________