AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

TrueCare recognizes a patient's right of access under HIPAA and the 21st Century CURES Act Information Blocking Rules. This form is for use when such authorization is required and complies with HIPAA Privacy Standards. All sections of this authorization must be completely filled out before TrueCare is permitted to disclose your protected health information.

First Name:	**Middle Initial:**	**Last Name:**
Name at Time of Treatment (if different than above):		

Phone:	**Date of Birth (MM/DD/YYYY):**	
RELEASE TO:	**RELEASE FROM:**	
TrueCare	**I hereby authorize TrueCare to obtain a copy of my records from:**	
Health Information Department	**Name:**	
400 S. Melrose Drive, Suite 200	**Address:**	
Vista, CA 92081	**City/State/Zip Code:**	
Phone: (760) 736-6717	**Phone:**	**Fax:**
ROI Department Fax: (877) 279-1995	**Delivery Method:** ☐ Mail ☐ Fax	

INFORMATION TO BE RELEASED (Check all that apply)	**Date(s) of service:** ________/ _______/ _________to _______/ ________/__________ Month Day Year Month Day Year ☐ **General health information**: Face sheet, problem list, office visit/progress notes, discharge/visit summary, ED records/summary, procedure/operative notes, consultations, medication lists. ☐ **Complete Hospitalization** ☐ **Other** (please specify): ________________________________ ☐ **Prenatal records only** **Results/report**: ☐Colonoscopy ☐DEXA Scan ☐Immunizations ☐Mammogram ☐Pap Smear ☐Radiology Reports ☐Lab/Pathology Results ☐EKGs ☐Other (please specify): _____________ ☐ **Reproductive Health Care** ☐**Alcohol/Drug Information** ☐**HIV related Information** ☐ **Mental Health** ☐ **Billing Records** ☐**Other** (please specify): ____________________________
PURPOSE OF REQUEST	☐ Continuity of Care ☐ Transfer of Care/Primary Care Provider change (PCP) ☐ Other (please specify): ____
PATIENT RIGHTS	TrueCare may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization. A copy of the original authorization is valid. You have a right to receive a copy of this completed authorization. **REVOCATION:** You or your personal representative may cancel this authorization for future releases by submitting a written request to **TrueCare, 400 S. Melrose Drive, Suite 200, Vista, CA 92081**. Your cancellation will not affect information that was released prior to receipt of the written request. **DURATION:** Authorization shall remain in effect for one year from the date of signature below. **REDISCLOSURE:** Once this information is released, it may not be protected under federal privacy law (HIPAA). State or other federal law may require the recipient to obtain your authorization before further disclosure.

REQUIRED SIGNATURES	**Name of Patient or Personal/Legal Representative (Please Print):**	**Relationship to Patient:**
	Signature of Patient or Personal/Legal Representative:	**Date Signed:**

For internal use by TrueCare ONLY	**MRN:**	**TrueCare Location:**	**Date Received:** **Received By:**