



Authorization for Disclosure of Protected Health Information

I, the undersigned individual or legal representative, hereby authorizes Crossover Health Medical Group, APC ("Crossover") to use, disclose, and/or receive the protected health information (PHI) described below with the following individual or entity:

Name of Individual or Entity

Address

Phone Number

Fax Number

Please be aware that once your information leaves Crossover, Crossover will no longer be able to protect that information and the recipients of your information may not be legally required to protect your information if the transfer is for a reason other than receiving medical care.

I understand that Crossover may not further disclose the PHI described on this authorization unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. I hereby release Crossover from any/all liability that may arise from the release of my PHI.

I further understand that I, or my authorized representative, has a right to receive a copy of this Authorization upon my request.

Crossover may not condition treatment, except as provided by law, on your decision whether to sign this Authorization.

I understand that I, or my authorized representative, may revoke this authorization in writing at any time, except as outlined in Crossover's Notice of Privacy Practices or to the extent that action has already been taken, by writing to Crossover Health Medical Group 101 W. Avenida Vista Hermosa, Suite 120, San Clemente, CA 92672.

Purpose of Release: _____ **Continuity of Care** _____ **Other (specify)** _____

Expiration Date of Authorization: _____

This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified.

Information to be Used or Disclosed (Select all that apply):

<input type="checkbox"/> Medication List	<input type="checkbox"/> Medical Bills	<input type="checkbox"/> Consultation Results
<input type="checkbox"/> List of Allergies	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Entire Record
<input type="checkbox"/> Most recent history and exam	<input type="checkbox"/> Most recent discharge summary	
<input type="checkbox"/> X-ray and imaging reports	<input type="checkbox"/> Lab results	
<input type="checkbox"/> Other (please specify): _____		

The following information will NOT be released without your written authorization. If you consent to the release of certain specified records, please initial each category below:

☐ I authorize the release of information pertaining to drug and/or alcohol abuse, diagnosis or treatment

☐ I authorize the release of HIV/AIDS test results

☐ I authorize the release of genetic testing information

☐ I authorize the release of mental health/psychiatric records

☐ I authorize the release of reproductive health records

Delivery Preference: Clinic Pick Up _____ Mail _____ Fax _____ Secure Email _____ Other (specify) _____

Initial the appropriate selection:

☐ **I am eighteen (18) years of age or older:**

I have the right to enter into this agreement and the permission of no other party is necessary for me to enter into this agreement. This document shall be binding upon my heirs, successors and assigns. I understand that this authorization is voluntary. I need not sign this form to assure treatment.

☐ **If the patient is aged 0 to 17:** I hereby warrant that I am the parent/Guardian of the minor named above, that I have read and understood this release and have legal authority to execute the above release. I hereby warrant that I am of full age and have every right to contract in my own name in the above regard. I state further that I have read the above authorization and release, prior to its execution, and that I am fully familiar with the contents thereof. I understand treatment is not conditioned on this authorization. If the patient is 12 to 17, the patient's specific consent may be required. Refer to state laws for minor consent permissions. Additionally, general guidance is available in 45 CFR 164.502 and 164.524.

Patient/Guardian Name: _____ **Patient DOB:** _____ **Relationship:** _____

Patient/Guardian Signature: _____ **Date:** _____

Address: _____ **Phone:** _____