crossover

Authorization for Disclosure of Protected Information

The undersigned hereby authorizes Crossover Health Medical Group, APC ("Crossover")to share the protected health information ("PHI") described below ____**to** or ___**from**

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 use or disclose the PHI described on this authorization unless another authorization is obtained from me or unless such use or 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):

___Medication List
___List of Allergies
___Most recent history and exam
___X-ray and imaging reports
___Other (please specify): _____
___Medical Bills
___Immunizations
___Most recent discharge summary
___Lab results
___Consultation Results
___Entire Record

The following information will NOT be released without your written authorization as indicated by initialing 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

Delivery Preference: ___Clinic Pick Up ___Mail ___Fax ___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 not eighteen (18): 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.

Patient/Guardian Name:_____Patient DOB:_____Relationship:_____

Patient/Guardian Signature:_____Date_____

Address:_____ Phone:_____