Healthy Living Primary Care

11634 Fair Oaks Blvd, Fair Oaks CA 95628
Phone: (916) 983-8868 Fax: (916) 983-8891 Email: records@healthylivingpc.com
Secure Upload at - https://tinyurl.com/HealthyLivingPC

AUTHORIZATION TO REQUEST HEALTHCARE INFORMATION

****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION****

Purpose: This form is used to request an individual's conditioned authorization to disclose protected health information resulting from the provision of health care to the individual solely to create protected health information for a third party. **This form may also be used to obtain authorization for use of disclosure of psychiatric notes if the appropriate box is selected below.**

Patient's Name:_____ Date of Birth:_____

I request and authorize **Healthy Living Primary Care**
To **receive** healthcare information for the patient named above **from** the following Medical Office/Hospital:

Name: _____

Address: _____

Phone: _____ Fax: _____

Protected Health Information to be Used and/or Disclosed: The specific protected health information we are asking you to authorize from the named party above Healthy Living Primary Care:

☐ Healthcare information relating to the following treatment, condition or dates:

_____

☐ All healthcare information

_____

☐ All Psychiatric and/or Psychotherapy notes

_____

Purpose of this Authorization: By signing this form, you will authorize the party named above to disclose the protected health information generated from that treatment to Healthy Living Primary Care.

Effect of Declining this Authorization: This authorization is a condition of Healthy Living Primary Care treating you. If you decide not to sign this authorization, we may decline to treat you.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Healthy Living Primary Care. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation. I also understand that, if I revoke this authorization, Healthy Living Primary Care may stop treating me.

Signature – You May Refuse to Sign This Authorization:
I have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that you may disclose my protected health information to the third parties described in this form for the purposes stated in this form.

Patient Signature: _____ **Today's Date**:_____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____ Relationship: _____

You Are Entitled to a Copy of this Authorization After You Sign It / THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED