AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO HOSPITAL/CLINIC FOR CONTINUITY OF CARE

PATIENT FIRST NAME: _____ PATIENT LAST NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER (*Optional*):_____

MED. REC. #:_____

I HEREBY AUTHORIZE THE FOLLOWING:

☐ Disclose the protected health information listed below from Ventura County Health Care Agency at CI to the following hospital/clinic.

☐ Disclose the protected health information listed below from specified hospital/clinic to Ventura County Health Care Agency at CI.

Name of Hospital/Clinic: _____ Address: _____

Telephone Number: _____ Fax Number: _____

I HEREBY AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION (*check all that apply):*

☐ Transfer Record
☐ Dictated Notes
☐ Progress Notes
☐ Laboratory Reports
☐ Pathology Reports
☐ Radiology Reports/Images
☐ Emergency Records
☐ Clinic Records
☐ Other: Please Specify: _____

DATES OF SERVICE REQUESTED FROM: _____ TO: _____

PURPOSE OF DISCLOSURE: Further Medical Care

EXPIRATION:
This authorization will become effective immediately and will remain in effect until _____ *(enter date)* at which time this authorization to use or disclose this protected health information expires. If the patient fails to specify an expiration date, this authorization will expire six months from the date on which it was signed.

I understand that I have a right to receive a copy of this authorization upon my request.

Copy requested and received: ☐ YES ☐ NO INITIAL: _____

SIGNATURE:

_____ _____
Signature of patient or legal/personal representative **Date**

If signed by a legal/personal representative of the patient, describe the representative's authority to act for the patient (*attach supporting documentation)*: _____

_____ _____
Name of health professional submitting request **Professional title**

_____ _____
Signature of health professional submitting request **Date/Time**