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www.lagunaniguelfmedical.com

Authorization to Disclose Protected Health Information

I hereby authorize Laguna Niguel Family Medical Center to disclose to the below named Facility/Physician.

OR

I hereby authorize the below named Facility/Physician to Disclose to Laguna Niguel Family Medical Center.

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

The following protected health information:

- Entire File
- Laboratory Results
- Imaging Results (xrays, CT scan, MRI, etc.)
- HIV Tests
- Progress Notes
- Medications
- Other: _____

I understand that I have a right to receive a copy of this authorization and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Laguna Niguel Family Medical Center has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Laguna Niguel Family Medical Center to be effective.

I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by the Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable California law.

Patient Name: _____ Date: _____

Signature: _____

Representative if patient is a Minor: _____