Temecula Valley
Family Physicians
Curtiss W. Combs, M.D.

Authorization for Release of Protected Health Information

I authorize Dr. Curtiss W. Combs, Temecula Valley Family Physicians, to release health information **TO:**

_____

(Specify facility name/title of person to receive information)

_____

(Street Address, City, State, Zip Code)

_____

(Area Code, Telephone Number, Extension, and Fax number, **MANDATORY**)

Information To Be Released (Check One or More MANDATORY):

[ ] Billing Statements	[ ] History & Physical Exams	[ ] Outpatient Clinic Reports
[ ] Consultations/Evaluations	[ ] HIV/AIDS Test Results	[ ] Pathology Reports
[ ] Discharge Summary	[ ] Laboratory Reports	[ ] Progress Reports
[ ] Entire Medical Record	[ ] Operative Reports	[ ] Radiology Diagnostic Images/Reports

The Purpose Of This Release is (Check One or More MANDATORY):

Continuing Care	Inspection of records	Insurance Claim
Legal Matters	Personal Copy	Second Copy

Other reason (Please Specify): _____

NOTICE:

I understand that information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). The recipient of this information is requested not to re-disclose this information without my authorization for disclosure. Temecula Valley Family Physicians/affiliates, its employees, officers and physicians are hereby release from any legal responsibility or liability for improper re-disclosure of the above information to the extent indicated and authorized herein.

My Rights:

* I understand this authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization ***except*** if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility with enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party.
* I may revoke this authorization at any time, provided that I do so in writing, and submit it to:

Curtiss W. Combs, M.D.
Temecula Valley Family Physicians
31720 Temecula Parkway Suite # 203,
Temecula, CA 92592
Tel 951-302-4700 Fax 951-302-4701

* This revocation will take effect when Dr. Curtiss W. Combs, Temecula Valley Family Physicians, receives it, except to the extent that Dr. Curtiss W. Combs, Temecula Valley Family Physicians has already relied on it. This authorization will automatically expire six months from the date of execution unless otherwise noted.
* I am entitled to receive a copy of it. I understand that the health information may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse.

_____ _____

Print Full Name Relationship to Patient, If Other Than Self

_____

Date of Birth

_____ _____

Signature of Patient or Patient's Legal Representative Date and Time