



Patient Label
For Office Use Only

Sycuan Medical Dental Center
Tel: (619) 445-0707

Website: <https://www.sycuanmedicaldentalcenter.org>

RELEASE OF INFORMATION FORM

At Sycuan Medical Dental Center, we prioritize the privacy and security of your health information. This form authorizes the release of health information as specified below:

YOUR RIGHTS: As a patient, you have several rights regarding the authorization of the use and disclosure of your health information:

- **Right to Inspect or Copy:** You have the right to inspect or obtain a copy of the health information to be used or disclosed per this authorization.
- **Right to Refuse to Sign:** You may refuse to sign this authorization, which will not affect your treatment except in limited circumstances. For example, if lab work is completed at another clinic that is intended for use by a provider at another clinic, refusal to sign this authorization may prevent the sharing of those results.
- **Right to Terminate or Revoke Authorization:** You may revoke this authorization at any time by submitting a written request to the SMDC Medical Records Department at the contact information provided below.

SMDC Medical Records Department
Contact Number: (619) 445-7196 ext: 103
Email: smdcmedicalrecord@sycuanmed.org
FAX: (619) 445-0901

I hereby authorize the release of my health information by:

Sycuan Medical Dental Center (SMDC)
Address: 5442 Sycuan Rd., El Cajon, CA 92019

TO Person or Organization: _____

Address: _____

Phone Number: _____ FAX Number: _____

Email Address: _____

Information to be released (please check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Radiology Reports and Films (specify dates): _____ |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Laboratory Reports (specify dates): _____ |
| <input type="checkbox"/> Physician Progress Notes | <input type="checkbox"/> Medication Administration Records |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> History & Physical Examination |
| <input type="checkbox"/> Physician Orders | <input type="checkbox"/> All of the Above |
| <input type="checkbox"/> Other (please specify): _____ | |

Please list the name(s) of a person(s) with whom we can share the patient's Protected Health Information (PHI) and/or who can pick up prescriptions in the event you are unable to. *(If none, please write "NONE")*

Purpose for Release of Health Information: The information described above is being released for the following reason(s):

Authorization Validity: This authorization for the release of confidential health information is effective immediately and will remain valid until one year from the date of my signature below unless an alternative expiration date or event is specified here. _____ (initial), _____ (insert date)

Scope of Authorization: The release of information is limited to the scope of treatment within the dates specified above. I acknowledge my right to refuse to sign this authorization and understand that signing is voluntary. I am entitled to review the information to be disclosed under 45 CFR § 164.524. _____ (initial)

Consent and Revocation: By signing below, I confirm that I have read and understood the terms of this authorization and hereby grant permission to the staff of the named disclosing facility to release information as outlined herein. I can revoke my authorization in writing at any time, except where actions have already been taken based on this authorization. _____ (initial)

Disclosure of Sensitive Health Information: I am aware that the information to be released may include records about alcohol and drug abuse treatment, mental health treatment, HIV testing and results, or AIDS information. I understand that further disclosure of my health information to parties other than those specified herein requires additional authorization from me. _____ (initial)

Re-disclosure and Privacy Protections: I acknowledge that once my health information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected by certain federal regulations, including 42 CFR Part 2 and HIPAA Privacy Rule unless the recipient is obligated to protect the privacy and security of the information under these regulations. _____ (initial)

Release and Indemnification: By signing this authorization, I release the facility from any legal responsibility or liability for the release of information as detailed in this document. I agree to indemnify and hold harmless the facility for acting under this authorization. _____ (initial)

Patient Name/Initials: *(please print)*: _____/_____

Patient Signature: _____

Patient Date of Birth: _____

Date Signed: _____

If Patient is unable to sign:

Representative Name/Initials: *(please print)*: _____/_____

Signature Representative: _____

Date Signed: _____

Witness Name {if required} *(please print)*: _____

Witness Signature/Date signed: _____/_____