E-mail: HIM@daphealth.org • Phone: 760-656-8409 • Fax: _____

Authorization for Release of Health Information

This Authorization is not valid if not filled out completely

Patient Information	
Patient Legal Name:	
Date of Birth:	
Phone Number:	
Address:	
City/State/Zip:	

Release/Request Records		**Purpose**	
I authorize DAP Health to: ☐ Release Records to: ☐ Request Records from: Person/Entity:			For the Following: (Select One)
Address:			☐ Continuing Care
City/State/Zip:			☐ Insurance
Phone/Fax/Email:			☐ Legal
			☐ Personal
			☐ Other:

Information to Release	
Specify Date for Information Selected Below **From:** **To:**	
☐ Office Visit/Progress Notes	
☐ OB/GYN Records	
☐ Psychiatric Progress Notes (Separate authorization required for Psychotherapy and Substance Use Disorder Records)	
☐ Labs	
☐ Medication List	
☐ Imaging Reports	
☐ Immunization	
☐ Other (Please Specify):	

Delivery	
☐ Pick-Up (Records exceeding 100 Pages will be put on a compact disc)	
☐ Fax	
☐ Mail	
☐ Encrypted Email (I understand that un-encrypted email is NOT confidential, can be intercepted, and read by others)	

Restricted Information	I understand the information to be released or disclosed may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), substance abuse, and/or mental health. I authorize the release or disclosure of this type of information **EXCEPT**: **Note: A separate authorization is required for psychotherapy progress notes**

Rights and Acknowledgements	By having signed this form, I understand that: 1. Health information used and disclosed in this authorization may be subject to re-disclosure and no longer protected by federal privacy regulations. 2. I have the right to revoke this authorization to release records at any time by writing to DAP Health, with the exception to the extent that action has already been taken based on this authorization (Submit to DAP Health, 1695 North Sunrise Way, Palm Springs, Ca 92262). Further details are found in the Notice of Privacy Practices. 3. This authorization to release health information is voluntary, treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. 4. I am entitled to a copy of this authorization.

Expiration	Unless otherwise revoked, the Authorization expires_____ (insert date or event). If no date is indicated this Authorization will expire 12 months after the date signed.

Signature	Signature: Representative Relationship: NOTE: If legal representative, in any capacity, please attach documents if not already filed with DAP Health	Date:

Staff Use Only	I have witnessed the execution of this authorization. Employee Name: Employee Signature: Date: