DESERT VALLEY MEDICAL GROUP, INC.
16850 Bear Valley Road
Victorville, CA 92392
Phone: (760) 241-8000 Ext. 8745
Fax: (760) 241-0464

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(1) I hereby authorize (Name of facility/Doctor: _____

Address: _____, to disclose the following information from the Health records of:

Patient Name: _____

Date of Birth: _____

Address: _____ Telephone: _____

_____ Patient Number: _____

Covering the period of healthcare:

From (date) _____ To (date) _____

(2) Information to be disclosed:

- ☐ Complete health record(s)
- OR if partial health record:
- ☐ Chart Inspection
- ☐ Consultation Reports
- ☐ SOAP Note
- ☐ Progress Notes
- ☐ Laboratory Tests
- ☐ X-Ray Reports

COPY CHARGES
.25 cents per page
Patient notified of standard copy fees.

Please initial _____

☐ Other (Please specify) _____

I understand that this will include information relating to (check if applicable):

- ☐ Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus)
- ☐ Psychiatric care / Mental Health
- ☐ Treatment for alcohol and / or drug abuse

(3) This information is to be disclosed to Name: _____

Address: _____ For The Purpose Of: _____

This disclosure shall not condition treatment or payment on the individual's providing authorization for the requested use or disclosure.

(4) I understand this authorization may be revoked in writing at any time, except with respect to action that has already been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 30 days from date signed below.

(5) I further understand that I have a right to inspect the protected health information to be used or disclosed, and to receive a copy of this authorization upon my request.
Copy requested and received: ☐ YES ☐ NO Initial _____

(6) The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(7) Information used or disclosed to any entity other than a health plan or health care provider may no longer be protected by the federal privacy law.

(8) Duration: This authorization shall become effective immediately and shall remain in effect until (date) _____

Signed: _____ (Patient) (Date)

_____ or (Legal Representative) (Relationship to Patient) (Date)

DVMG 26-88 (7/03)