Diabetes Care Center
A Medical Corporation

☐ No Records Found
☐ Not Our Patient

1260 South Main St, Suite 202, Salinas, CA 93901
Telephone: (831) 769-9355 • Fax: (831) 754-4955

Patient Authorization for Use and Disclosure of Protected Health Information

Patient Information

Name: _____ Social Security No: _____

Address: _____

Date of Birth: _____/_____/_____ Phone No: _____

As required by the Health Information Portability and Accountability Act of 1996 (HIPPA) and the California Law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving authorization for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. This authorization includes reports, correspondence, test results, and any other information in the records, whether generated by the authorized provider of another entity.

I hereby authorize and request: ☐ Doctor ☐ Hospital

Name: _____

Address: _____

Phone No: _____ Fax No: _____

To release my records to:

Name: Diabetes Care Center

Address: 1260 South Main St, Suite 202, Salinas, CA 93901

Phone No: (831) 769-9355

Please release:

☐All records- Any and all health information other than psychotherapy notes may be released, including, but not limited to mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specified: _____

☐Dates of Service From: _____ to _____ ☐Lab Results ☐X-Ray Reports

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire one (1) year from the date of this authorization. I release Karen Winn, MD from any/all legal liability that may arise from the release of this information to the party named above.

I understand that I have the right to receive a copy of this authorization.

Signature of Patient or Legal Guardian: _____ Date: _____

Relationship to Patient: _____