Stuart R. Winthrop, M.D.

** Per HIPAA Regulations, please print completed form and mail to our office address below*

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this form authorizes the use and or disclosure of individually identifiable health information as specified herein and is consistent with California and Federal law concerning patient record confidentiality. Failure to provide all information may invalidate this form.

I understand that an administrative fee applies for copying records for personal use (there is no charge when sending to another physician or provider) as follows: $6.00/quarter hour, plus $0.25/page. I, the patient understand that I may inspect or obtain a copy of the medical records or PHI that I am asking be disclosed

Part 1. Use and/or Disclosure of Protected health Information (PHI)

I wish to authorize the use/or disclosure of my medical records:

From: (doctor, organization)_____

(address)_____

(phone and fax)_____

To: (doctor, organization)_____

(address)_____

(phone and fax)_____

This authorization applies to the following records I have checked below:

- ☐ All records in your possession
- ☐ All records in your possession other than those referring to:
  - ☐ Results of tests for HIV and/or AIDS
  - ☐ Psychiatric records
  - ☐ Substance abuse records
- ☐ Only the following medical records, including dates: _____

_____

Part 2. If a Party Other than the Patient seeks Authorization:

Protected Health Information will be used for the following purpose(s):

☐ Continuity of Care ☐ Insurance ☐ Changing Provider

☐ Personal (at patient request) ☐ Legal Process/Action ☐ Other: _____

Patient Name: _____ DOB: _____

Please continue on back
⇒ ⇒ ⇒

515 E. Micheltorena St., Santa Barbara, CA 93103
Office: (805) 963-4272 LASIK Line: (805) 730-9111

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Part 3. Expiration:

This authorization expires: _____

Part 4. Restrictions (To Requestor when not the Patient)

California law prohibits the Requestor from obtaining further disclosure of PHI unless the Requestor obtains another Authorization from the Patient or unless further disclosure is specifically required or duly permitted by law.

Note to Patient: If you have authorized the use and/or disclosure of your PHI to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law requires recipients of your PHI from redisclosing your information except with your written authorization or as specifically required or permitted by law.

Part 5. Your Rights and Responsibilities:

1. You may refuse to sign this Authorization
2. You may revoke this authorization in writing at any time, but your revocation must be made by your or your agent in writing and signed, dated and delivered to the address at the top of this request form.
3. Your revocation is effective upon receipt but will not be effective to the extent that the Requestor or others may have already acted in reliance upon this authorization
4. You have the right to review and receive a copy of this Authorization.

Patient Signature and Authorization:

Name of Patient: _____ Phone: _____

Address: _____

My signature reflects my wishes for the transfer of my PHI as stated above:

Signature of Patient: _____ Date: _____

Signature of Patient Agent*: _____ Date: _____

State Relationship to Patient:

- ☐ Parent or guardian of a minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of a deceased patient**
- ☐ Spouse or person financially responsible***

*Two Agent Identifiers are required:

(1) _____ (2) _____

** Death certificate required *** valid only in processing dependent health care coverage

Patient Name: _____ DOB: _____

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