INNOVATIVE INTEGRATED HEALTH, INC.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

DATE:	ID VERIFICATION (TYPE):
PATIENT NAME:	
BIRTHDATE:	ID VERIFIED BY:

I authorize:_____
(Name of person or facility which has information and full address)

_____
Street address City State Zip Code

to release health information to:_____
(Name of person or facility to receive health information and full address)

_____
Street address City State Zip Code

- ☐ Fresno PACE Fax: (855) 629-6635
- ☐ OC PACE Fax: (855) 400-8474
- ☐ Bakersfield PACE Fax: (855) 621-3928
- ☐ Intake Fax: (855) 955-1990

The purpose of this release is for (check one or more):

- ☐ Continuity of care or discharge planning
- ☐ At the request of the patient/patient representative
- ☐ Other (state reason):_____

Please specify the health information you authorize to be released. Please check all that apply.
For dates of service:_____

- ☐ **Emergency Room Visit** (e.g. ED provider notes, radiology reports, lab and diagnostic, consults and procedure notes)
- ☐ **Entire Hospital Record** (e.g. History and physical, consult, operative report, discharge summary, lab, radiology reports, nursing notes, progress notes)
- ☐ **Clinic or Office Visit** (e.g. Progress notes, office notes, procedure notes, operative notes, lab, diagnostic and radiology reports)
- ☐ **Other Records** (not listed above, please specify type):_____

Delivery Method (select all that apply): ☐ Mail ☐ Fax ☐ Pick-up by Participant ☐ Pick-up by Personal Rep Name:_____

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

- ☐ Information pertaining to drug and alcohol abuse, diagnosis, or treatment (42 C.F.R §§2.34 and 2.35).
- ☐ Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, *et. seq.*)
- ☐ Release of HIV/AIDS test results (Health and Safety Code §§120980 (g)).
- ☐ Release of genetic testing information (Health and Safety Code §§124980 (j)).

EXPIRATION OF AUTHORIZATION

This authorization expires on disenrollment from the IIH PACE Program, unless date is otherwise specified here: _____.

_____ _____
Print Name Signature (Patient, Parent, Guardian)

_____ _____
Patient Phone Number (Reason Patient unable to sign)

_____ _____
Date Time Name & Relationship to Patient (Parent, Guardian, Conservator, Patient Representative, Interpreter

NOTICE
IIH and many other organization and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Return Completed Authorization to One (1) of:

Fresno PACE – Medical Records
2042 Kern St.
Fresno, CA 93721
Fax: (855) 629-6635

OC PACE – Medical Records
1125 North Magnolia Ave
Anaheim, CA 92801
Fax: (855) 400-8474

Bakersfield PACE – Medical Records
1800 Height St.
Bakersfield, CA 93305
Fax: (855) 621-3928

YOUR RIGHTS
This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to Medical Records. The revocation will take effect when PACE receives it, except to the extent PACE or others have already relied on it. You are entitled to receive a copy of this Authorization.