Advantage Plus Medical Center
Family, Occupational and Addiction Medicine

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) TO ADVANTAGE PLUS MEDICAL CENTER

Instructions: To authorize the use and disclosure of your protected health information (PHI), please complete the information below, sign in the space provided and return to Advantage Plus Medical Center

Patient Information				
	Name (Last, First, MI)		**SSN**	**Date of Birth**
	AKA	**Street Address, Apt. #**		
	City	**State**	**Zip Code**	**Home Phone** ( )

1. **I hereby authorize:**
2. Name _____

   Address _____

   City, State, Zip Code _____

   Phone:_____ Fax: _____

   to disclose the above individual's "protected health information" to ***Advantage Plus Medical Center*** located at ***18021 Sky Park Circle, Building 68 Suite. G, Irvine, Ca 92614. Phone# (949) 260-0744/ fax# (949) 260-0750***

   Covering records from on or about (Date)_____to (Date) _____

3. **PHI to be disclosed (Please initial all that apply and identify clinic and time period as necessary)**

☒ Summary PHI ☐ Operative Note ☐ Diagnostic test (e.g. Lab, X-ray, Radiology) _____
☐ Discharge Summary ☐ Pathology ☐ Outpatient Record _____
☐ Consultation ☐ Emergency Department ☐ Outpatient Records _____
☐ Mental Health/ Psychological Notes PHI ☐ Alcohol/ Substance Abuse Treatment PHI
☐ HIV Results/ AIDS Treatment PHI
☐Other _____

CONFIDENTIAL INFORMATION

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department at Advantage Plus Medical Center. I understand that the revocation will not apply to information that has already been released in response to this authorization.
5. Expiration date or expiration event to this authorization: _____ (specify new date)
6. I also understand that I have the right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form. You also have a right to receive a copy of this form after you have signed it.

_____ _____
(Signature of Patient/ Representative/ or Legal Guardian) **(Date)**

_____ _____
(If other than patient, relationship to patient) **(Notary/ Witness)**

Please return the request medical records to Advantage Plus Medical Center
18021 Sky Park Cir., Bldg. 68 Ste. G, Irvine, Ca 92614.
T) 949-260-0744/ F) 949-260-0750