Richmond District Medical Group

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Section 1 – Patient Information:

Patient's Name: _____Date of Birth: _____

Address _____City, State, Zip_____

Email:_____Phone: _____

Section 2 – Authorization and Type of PHI to be Released:

I hereby authorize Richmond District Medical Group, and Datalink ITS to disclose my individually identifiable Protected Health Information ("PHI") in the manner described below. I understand that my PHI may be re-disclosed by the person or entity receiving my PHI, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such re-disclosure by the person or entity receiving my PHI. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. This authorization covers the following PHI (mark all that apply):

❏ Medical Records ❏ Psychotherapy Notes ❏ Genetic Test Results ❏ HIV Test Results

❏ Drug/Alcohol Abuse records

Amount of PHI

❏ Entire PHI in the chosen category [Example – any/all PHI, any/all dates] **OR**

❏ Please limit use and disclosure of my PHI to: [indicate limitations below]

_____

[Examples – "Lab results from July 1998," "Doctors Notes from January 2001 to present"]

Section 3 – Party Authorized to Receive Patient's PHI. The recipient(s) of my PHI is (are):

Name_____

Address_____City, State, Zip_____

Email: _____Phone: _____ Fax: _____

❏ Send my records via email. (Select this option for fastest delivery)

❏ I have additional recipients listed on page 4 of this authorization.

Richmond District Medical Group

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient's Name: _____Today's Date: _____

Section 4 – Purpose, Expiration and Revocation of Authorization

I authorize my PHI to be used and disclosed (Check all that apply)

❑ Patient Access ❑ To Assist with care ❑ For Insurance ❑ For Legal ❑ Other: _____

This authorization will expire: ❑ 6 Months ❑ Other: _____

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by Richmond District Medical Group/Datalink ITS in reliance on this authorization prior to receipt of my request for revocation or modification.

Section 5 – Fees and Payment Options

The fees to obtain your medical records are as follows. Check all that apply:

❑ $45[1] Per each complete copy of your medical record file via secure link.

❑ $10 Additional fee if you would like your file mailed on a USB Drive (Total $55).

❑ I have included a check with this request: Check #: _____ Amount: $ _____

❑ I authorize Datalink ITS to use the following credit/debit card information to charge me $_____for the requested information.

I understand that Datalink will charge my card upon receipt of this authorization.

Card Type: _____Card Number: _____

Card Expiration (mm/yy): _____CVC Code:_____ (on back of card)

Name on Card:_____Billing Zip Code: _____

Card Holder's Signature: _____

FAX COMPLETED REQUEST TO 562-977-3173 OR EMAIL TO: CUSTOMERSERVICE@DATALINKITS.COM
IF PAYING BY CHECK MAIL COMPLETED FORM AND CHECK TO:
DATALINK ITS 6285 EAST SPRING STREET 103 LONG BEACH CA 90808
QUESTIONS - 888-997-7299 OR CUSTOMERSERVICE@DATALINKITS.COM

[1] Fees are compliant with CA Health and Safety Code 112130

Richmond District Medical Group

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient's Name: _____Today's Date: _____

Section 6 – Processing and Delivery Method

Datalink processes all requests for release of information in the order received. Turn-around time may vary depending on the information you requested, the purpose of your request, the location and availability of your medical records file, and review by your physician. Therefore, please allow 7-10 days for your request to be processed. To check status you may call Datalink at 888.997.7299, option 1. The information you requested will be forwarded either by email or fax. If you did not select email or did not provide a fax number, Datalink will mail the authorized information to your selected recipient on a USB via US Mail. Paper copies are available for an additional fee of .20 cents per page plus postage. If you require paper copies, you will be billed for the remaining balance due when your request is complete.

Section 7 – Patient Signature

In addition to approving the release of your protected health information, your signature below indicates your agreement to pay the fees outlined above.

Signed:_____Dated:_____

If not signed by the patient, please indicate relationship:

❑ Parent, guardian or caregiver of a minor patient*

❑ Guardian or conservator of an incompetent patient*

❑ Beneficiary or personal representative of a deceased patient*

❑ Other _____[SPECIFY RELATIONSHIP]*

*please provide documentation supporting your right to access patient's PHI.

Need Help: Contact Datalink at 888.997.7299, X1 Email: customerservice@datalinkits.com

If paying by credit or debit card you may fax this form to 562-977-3173 or email to: customerservice@datalinkits.com or, if paying by check, mail your completed form and check to: Datalink ITS Inc. 6285 E Spring St 103 Long Beach CA 90808.

Next page is *optional* for additional recipients.

FAX COMPLETED REQUEST TO 562-977-3173 OR EMAIL TO: CUSTOMERSERVICE@DATALINKITS.COM
IF PAYING BY CHECK MAIL COMPLETED FORM AND CHECK TO:
DATALINK ITS 6285 EAST SPRING STREET 103 LONG BEACH CA 90808
QUESTIONS - 888-997-7299 OR CUSTOMERSERVICE@DATALINKITS.COM

Richmond District Medical Group

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient's Name: _____Today's Date: _____

Please Note: Section 8 is optional. If you only require 1 copy, please disregard section 8.

Section 8 – Additional Recipients (if applicable, otherwise leave blank)

The additional recipient(s) of my PHI is (are):
Name_____

Address _____City, State, Zip_____

Email: _____Phone: _____ Fax: _____
❑ Send my records via email. (Select this option for fastest delivery)

The additional recipient(s) of my PHI is (are):
Name_____

Address _____City, State, Zip_____

Email: _____Phone: _____ Fax: _____
❑ Send my records via email. (Select this option for fastest delivery)

The additional recipient(s) of my PHI is (are):
Name_____

Address _____City, State, Zip_____

Email: _____Phone: _____ Fax: _____
❑ Send my records via email. (Select this option for fastest delivery)

FAX COMPLETED REQUEST TO 562-977-3173 OR EMAIL TO: CUSTOMERSERVICE@DATALINKITS.COM
IF PAYING BY CHECK MAIL COMPLETED FORM AND CHECK TO:
DATALINK ITS 6285 EAST SPRING STREET 103 LONG BEACH CA 90808
QUESTIONS - 888-997-7299 OR CUSTOMERSERVICE@DATALINKITS.COM