



Southern California Physicians Managed Care Services, Inc. ("SCPMCS") is dedicated to ensuring the protection of the identifying and medical information of patients and their responsible representatives, guardians, conservators and health care agents (collectively, "Representatives"). SCPMCS is obligated to obtain authorization from patients prior to releasing their identifying and medical information to third parties in certain instances. By signing this authorization, you are agreeing that SCPMCS may release certain information to the individual or entity identified below for the purposes described below.

**AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION**

I, (please check one) the undersigned patient ("Patient") or the undersigned Representative of the Patient ("Representative"), hereby authorize SCPMCS to disclose the Patient's information as indicated below to _____ located at _____.

CLAIMS From _____ to _____
Date Date

AUTHORIZATION From _____ to _____
Date Date

MEMBER STATUS From _____ to _____
Date Date

I understand that I am not required to sign this authorization and that if I should choose not to sign this authorization Patient's treatment and enrollment in Patient's health plan will not be affected in any way.

If I choose to sign this authorization, I may revoke it at any time by providing a written notice of revocation to SCPMCS. I understand SCPMCS shall not be liable for its disclosure of information under this authorization if such disclosure is made in reliance upon this authorization prior to the date SCPMCS receives my notice of revocation of this authorization.

I understand that if my information is disclosed as requested herein, it may be redisclosed and no longer be protected by federal privacy rules.

This authorization will expire automatically upon _____ or on _____.
[Specify Event] [Specify Date]

Patient's Name Telephone No.: _____
Mailing Address: _____

Representative's Name (if applicable) Telephone No.: _____
Mailing Address: _____

Signature of Patient or Representative Date: _____

Nature of Relationship to Patient