

SAN DIEGO PHYSICIANS MEDICAL GROUP

San Diego Physicians Medical Group ("SDPMG") is dedicated to ensuring the protection of the identifying and medical information ("PHI") of Patients. SDPMG is obligated to obtain authorization from Patients and their responsible representatives, guardians, conservators and health care agents (collectively, "Representatives") prior to releasing identifying and medical information to third parties in certain instances. By signing this authorization, you are agreeing that SDPMG may release certain information to the individual or entity identified below for the purposes described below.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, the undersigned PATIENT OR Patient's LEGAL REPRESENTATIVE authorize SDPMG to disclose the following information to:

Name of Person Authorized to Receive Access to Patient PHI

Relationship to Patient

CLAIMS STATUS and PAYMENT INFORMATION

AUTHORIZATION STATUS

MEMBER STATUS and DEMOGRAPHIC INFORMATION

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 SDPMG. I understand SDPMG 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 SDPMG 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 NAME

Patient Telephone No: _____

Patient Mailing Address: _____

PATIENT SIGNATURE

EFFECTIVE DATE OF AUTHORIZATION

This section should only be used if form is being completed and signed by Patient's legal representative. A copy of the Power of Attorney must be on file with SDPMG or accompany this form BEFORE the release by Patient's Representative is valid.

LEGAL REPRESENTATIVE'S NAME

Rep. Telephone No: _____

Rep. Mailing Address: _____

LEGAL REPRESENTATIVE SIGNATURE

EFFECTIVE DATE OF AUTHORIZATION