Comprehensive Pulmonary and Primary Care
Physicians of Orange County

PLEASE SEND TO:
Mail: Comprehensive Pulmonary and Primary Care
of Orange County
1 City Blvd, Suite 1100
Orange, CA 92868
Phone: (714) 361-6600 | Fax: (714) 919-8838
Email Requests To: medrecords@cppcorange.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information:

Patient Name:_____ DOB:_____

Address: _____ City:_____

State: _____ Zip: _____ Phone #: _____

Authorization:

I hereby authorize **Comprehensive Pulmonary and Primary Care of Orange County** to release my health information to:

Recipient Name:_____

Address:_____ City: _____ State: _____

Zip: _____ Phone #:_____ Fax #: _____

Information Disclosure:

- ☐ All Record(s)
- ☐ Progress Note(s)
- ☐ Radiology Report(s)
- ☐ Laboratory Result(s)
- ☐ EKG
- ☐ PFT
- ☐ Immunizations
- ☐ Other (specify):_____

Special Authorization:

I specifically authorize release of the following information (if not initialed the specified information will be excluded):

☐ HIV/AIDS-Related Information_____ (initial) ☐ Substance Abuse_____ (initial)

☐ Mental Health_____ (initial) ☐ Genetic Testing_____ (initial)

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Expiration:

This authorization shall become effective immediately and shall remain in effect for **ninety (90)** days from the date signed.

Restrictions:

California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

Signature *(as required by law):*

SIGNATURE: _____ Date: _____
(Patient/Legal Guardian or Representative)

If signed by other than the patient, print name and relationship:

Name: _____ Relationship: _____