Comprehensive Pulmonary
and Primary Care
Physicians of Orange County

# 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**
1010 West La Veta Avenue, Suite 750
Orange, CA 92868
Phone: (714) 361-6600 | Fax: (714) 919-8804

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): _____

Comprehensive Pulmonary
and Primary Care
Physicians of Orange County

**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: _____