Santa Lucia Medical Group
1336 Natividad Road
Salinas, CA 93906
831.754.4444

Authorization to Use or Release Protected Health Information

I hereby authorize use or release of the named individual's health information as described below:

Patient Name: _____ Date of Birth_____ Social Security Number_____

Address (street, city, state, zip code):_____ Telephone Number_____

I hereby authorize Santa Lucia Medical Group, to release copies of portions of my medical record to:

_____

_____

I hereby authorize Santa Lucia Medical Group, to obtain copies of portions of my record from:

_____

_____

Treatment Dates: _____ **Purpose of Request**: _____

The following information is to be disclosed: (*Please check one box for each item.*)

Yes	No	
☐	☐	..... Physician Notes
☐	☐	..... Lab Results
☐	☐	..... X-Ray Reports
☐	☐	..... MRI Scans
☐	☐	..... Cardiac Studies
☐	☐	..... Other _____

Disclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I Understand that the revocation will not apply to information already released based on this authorization.

Other Rights:

a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (If I do not specify an expiration date, even, or condition, this authorization will expire in 12 months.) _____

I understand and agree that the information below will be disclosed if I place **My Initials** in the applicable space next to the type of information.

____ HIV/ AIDS testing/treatment **____Mental Health Records**

____ Alcohol/ Drug Abuse Records

Signature of patient or legal representative: _____ Date: _____

If signed by legal representative, relationship to patient: _____

Received by: _____

SANTA LUCIA MEDICAL GROUP, INC.

1336 Natividad Rd., Salinas, CA 93906
(831) 754-4444

PATIENT REGISTRATION INFORMATION

Acct.# _____

LAST NAME	FIRST	SEX M F OTHER:	MI	DATE OF BIRTH MM	DD	YY

OTHER NAMES USED: LAST NAME	FIRST NAME	SEX M F OTHER:	DOB	SS#

ADDRESS:

Billing _____ City _____ State _____ ZIP _____

Home #_____ Cell # _____ Work # _____

By providing my cell number, I give SLMG permission to remind me of appointments via text.

Employer_____ Name of Insurance _____

S.S. #_____ - _____ - _____ I.D. or Driver's Lic. # _____

If Married, Spouse Name _____ Birthdate _____

Employer_____ Name of Insurance _____

S.S. #_____ - _____ - _____ I.D. or Driver's Lic. # _____ Wk # ( ) _____

IF MINOR, who does child reside with? Father Mother Parents or Guardian (Please fill out if under parents insurance)
Circle one

Marital Status S M W D SEP

Name of Father/Guardian_____ Birthdate _____

Employer_____ Name of Insurance _____

S.S. # _____ - _____ - _____ I.D. or Driver's Lic. # _____ Wk # ( ) _____

Name of Mother/Guardian _____ Birthdate _____

Employer_____ Name of Insurance _____

S.S. #_____ - _____ - _____ I.D. or Driver's Lic. # _____ Wk # ( ) _____

What other person do you authorize to disclose Protected Health Information and financial information?

Name:_____ Date of birth:_____ Relationship:_____

Phone #:_____ Address: _____

IN CASE OF EMERGENCY NOTIFY

Name: _____ Phone Number:_____

Relationship:_____

I accept financial responsibility for payment for any service(s) provided or if it is not covered by my insurance. I agree to pay all copayments, deductibles and coinsurance, at the time services are rendered.

Signature(s) of financial responsibility:

_____ _____

Print Name Date Signature Date

Preferred Language: **Spanish** ☐ **English** ☐ **Other:** _____

Allergic to any Medication or Drugs _____ **Preferred pharmacy & address:** _____

Initials _____