

The City of Oceanside
Patient Authorization to Use and Disclose Protected Health Information

Patient Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Date of Birth: _____

By signing this Authorization, I hereby direct the use or disclosure by the City of Oceanside of certain protected health information (PHI) pertaining to the patient listed above. This Authorization concerns the following information about the patient:

This information may be used or disclosed by the City of Oceanside and may be disclosed to:

I understand that I have the right to revoke this Authorization at any time, except to the extent that the City of Oceanside has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to the City of Oceanside's HIPAA Privacy Officer:

Lynne Seabloom
300 N. Coast Highway
Oceanside, Ca. 92054
760-435-4103
Lseabloom@ci.oceanside.ca.us

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that my written authorization is not required for the City of Oceanside to use my protected health information for treatment, payment and healthcare operations.

I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization. The Authorization is being requested by the City of Oceanside for the following purpose(s):

The use or disclosure of the requested information will ___/will not ___ result in direct or indirect remuneration to the City of Oceanside from a third party.

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

This authorization expires on: _____ (date or event).

Signature: _____ **Date:** _____

Personal Representative Information (if signer is different from patient):

Name: _____

Relationship to Patient (parent, legal guardian, etc.): _____

Description of the authority of personal representative:

Street Address: _____

City: _____ State: _____ Zip Code: _____