GO EAST MEDICAL SERVICES
行 健 醫 療 中 心

P.O. Box 3306, Daly City, CA 94015
Email: eroi@gems-lv.org

GEMS MRN:

NAME:

DATE OF BIRTH:

EMAIL:

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Completion of this document authorizes the use or disclosure of health information about you. **Please fill in completely.**

I AUTHORIZE

_____
Name of Disclosing Party

_____
Address/Email Address/Fax Number

_____
City State Zip Code

TO DISCLOSE TO

_____
Name of Recipient

_____
Address/Email Address/Fax Number

_____
City State Zip Code

REQUESTED FORMAT: (Please select one):

☐ Email (encrypted) ☐ Email (unencrypted)** ☐ Patient Portal ☐ Fax
☐ Sharing of PHI (to authorize exchange between the organizations/persons listed above.)
☐ Paper: ☐ Pick-up **OR** ☐ Mail ($0.25/page fees may apply)

****Note:** Sending information over unencrypted email is not secure and increases risks that your information could be intercepted, viewed, copied, or shared by an unauthorized third party. By selecting the "Email (unencrypted)" option, I acknowledge that GEMS has warned me of the risks, and I still prefer and give permission to GEMS to send the requested records through unencrypted e-mail.**

SPECIFY THE HEALTH INFORMATION FOR DATES OF SERVICE:

From: ____/____/____ To: ____/____/____

By checking the box(es) below, I specifically authorize release of the following:

☐ **Complete Medical Information** ☐ Office Visit Notes ☐ Lab/Pathology Reports
☐ Immunizations ☐ Radiology Reports (CT, MRI, X-Rays, etc.)
☐ Other: _____

PROTECTED CLASSES OF INFORMATION:

By checking the box(es) below, I specifically authorize release of the following:
☐ Drug and Alcohol Abuse Diagnosis or Treatment Records
☐ Mental/Behavioral Health Diagnosis or Treatment Records
☐ HIV Test Results ☐ Genetic Testing Results ☐ Psychotherapy Notes

The release of the above-specified information is for the purpose of:

☐ Patient/Legal Representative Request ☐ Disability Eligibility ☐ Continuity of Care
☐ Continuing Medical Care by GEMS Provider: _____
☐ Other: _____

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DURATION: This authorization will be effective on the date of my signature and will remain in effect for one (1) year from the date of signature unless a different date is specified here _____(Date).

REVOCATION: I understand that I may revoke this authorization at any time by writing to GEMS HIS Department P.O. Box 3306 Daly City, CA 94015. My revocation will be effective upon receipt but will not apply to any information that was disclosed based on this authorization before the revocation is received.

REDISCLOSURE: I understand that once my health information is disclosed, it may no longer be protected by the federal regulations governing the privacy and security of health information.

MY RIGHTS: I understand that I may refuse to sign this authorization and GEMS may not condition my treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization, except where disclosure is necessary for treatment or eligibility for health care benefits. I understand that I may request a copy of this authorization.

Signature of Patient or Legal Representative*	Date
Name of Legal Representative	Relationship of Legal Representative
Signature of Witness (Required if patient is unable to sign)	Date

** If you are requesting information to be sent to yourself or to a third party under your right of access to your health information, you may choose unencrypted email. If this authorization request is from a third party, GEMS must send the information in a secure manner.

STAFF USE ONLY
☐ Emailed ☐ Faxed ☐ Mailed ☐ In-Person Staff Initial _____ Date _____