

PRIVACY ACT

BALBOA MEDICAL GROUP
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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

LAST NAME: _____ FIRST NAME: _____ MI _____

BIRTHDATE: _____ - _____ - _____ SOCIAL SECURITY # _____ - _____ - _____
MONTH DAY YEAR

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- * A basis for planning my care and treatment
* A means of communication among the many healthcare professionals who contribute to my care.
* A source of information for applying my diagnosis and surgical information to my bill.
* A means by which a third-party payer can verify that services billed were actually provided.
* A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I REQUEST MY INFORMATION INCLUDING RESULTS TO BE RELEASED TO THE FOLLOWING PERSON(S):

NAME: _____ RELATION: _____ TEL#(_____) _____

NAME: _____ RELATION: _____ TEL#(_____) _____

NAME: _____ RELATION: _____ TEL#(_____) _____

NAME: _____ RELATION: _____ TEL#(_____) _____

NAME: _____ RELATION: _____ TEL#(_____) _____

I REQUEST MY TEST RESULTS OF A DETAILED MESSAGE BE LEFT ON OR SENT TO:

- MY ANSWERING MACHINE @ HOME MY MOBILE/ CELL PHONE#(_____)
MY VOICEMAIL @ WORK MY FAX #(_____)
MAILED TO MY HOME ADDRESS

X _____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

DATE

WITNESS _____