Office of Dr. Michael N. Rutman, D.O., AMC
North Coast Internal Medicine

Authorization for Use or Disclosure of Protected Health Information
Michael N. Rutman, D.O., A.M.C.
2355 So. Melrose Dr., Vista, CA 92081
9850 Genesee Ave., Suite 430, La Jolla, CA 92037
(760) 942-2524 Phone (760) 942-1657 Fax

As required by the Health Information Portability and Accountability Act ("HIPPA") if 1996 and California law, North Coast Internal Medicine may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving your permission for the uses and disclosure described below. Please be aware that once your information leaves Michael N. Rutman, D.O., A.M.C., we will no longer be able to protect that hereby release of Michael N. Rutman, D.O., A.M.C. from any and all legal liabilities that may arise from the release of this information to the party listed below.
I hereby authorize Michael N. Rutman, D.O., A.M.C.to obtain or disclose health information concerning:

Patients Name _____ Date of Birth _____

Health information to be used or disclosed (check those which are appropriate):
Entire Medical Record
History/Physical Exams Consultation Reports Progress Notes Laboratory Test
X-ray Results Telephone Messages Medication Prescribed Psychotherapy Notes
Only dates of service from _____ to _____

I understand this information may include information relating to mental health diagnosis and treatments, AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, STDs (Sexually Transmitted Diseases) or other communicable diseases and counseling and/or treatment for alcohol and/or drug use/or abuse.

Therefore, I DO NOT authorize the release of this type of information.

The requester may use medical records and type of information authorized only for the following purposes:
Continuing Care Inspection of Record Legal Matter
Insurance Claim Personal Copy Second Opinion
Other (Please Specify): _____

Information May be TRANSFERRED to:
Physician or Facility Name and Address:
_____
_____
_____
_____

Transfer of Information FROM:
Physician Or Facility Name and Address:
Michael N. Rutman, D.O., A.M.C.
North Coast Internal Medicine
2355 So. Melrose Dr.
Vista, CA 92081

Cancellation Notice: Records releases are accomplished in as little as 2-3 days, but no longer than 15 days. You have a right to withdraw your authorization. I understand authorization may be revoked in writing at any time, according to Michael N. Rutman, D.O., A.M.C.'s Notice of Privacy Practices. Unless otherwise revoked, this information will expire (6) months from the authorization date.

After medical provider review, patients will be notified that records from outside the facility will be destroyed unless picked up within 10 days of notification. A minimum of $5.00 fee applies to requests to mail and may increase depending on postage and weight.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ **Parent or Guardian of Minor Patient**
I hereby declare under penalty of perjury, that I am the natural or adoptive parent or legal guardian of said child and there is no court order restricting or prohibiting my access to such medical records.
☐ **Guardian or conservator of an incompetent patient or representative of deceased patient.**

Name of Patient: _____ **Date of Birth:** _____
(Office Use Only Below)
☐ Patient will pick-up. Date of pick up: _____ ☐ Call when ready (phone #) _____