CIRCE HEALTHCARE SOLUTIONS, INC.
PERSONALIZING PRIMARY CARE

AUTHORIZATION TO RELEASE/DISCLOSE HEALTH INFORMATION

(Request for Outside Records to be Sent to Circe Health Care Inc.)

1. I authorize (provider/Facility)_____

(Address)_____

(Phone)_____(Fax)_____

To furnish health information as described below on:

(Name of Patient):_____Date of Birth:_____

2. **This authorization is limited to the following type and amount of information:**

{ } Medical Records for the past 2 years { }Immunization Record

{ } Medication List { } Other_____

{ } Laboratory Results _____

{ } X-ray and Imaging Results { } Specific Date Of Service_____

I specifically authorize release of the following information (check as appropriate):

{ } Mental health treatment information_____(initials)

{ } HIV test results_____(initials)

{ }The following substance use disorder treatment information:_____

_____(Initials)_____

Please send the requested information to: (Provider/Dept)_____

Circe Health Care Inc.

74000 Country Club Suite G2
Palm Desert CA, 92260
Phone: 760-773-4948 Fax: 760-773-4910 or 1-844-946-0546

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5. The Purpose of the requested release or disclosure:

{ } Patient request { } Continuation of care

{ } Application for insurance { } Other_____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocations will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorizations will expire on the following date:_____. If I fail to specify an expiration date, this authorization will expire in 1 year.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re disclosure and the information may not be protected by federal confidentiality rules. I have a right to receive a copy of the authorization.

Signature of Patient or Legal Representative:_____

Date:_____

If Signed by a Legal Representative, Relationship to Patient:_____

Print Name of Legal Representative:_____

Patient name:_____

Date of Birth:_____