AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF HEALTH INFORMATION/MEDICAL RECORDS TO THE CITY OF SAN DIEGO, ITS AGENT(S) OR LEGAL REPRESENTATIVE(S)

EXPLANATION: This form authorizes the City of San Diego, it agent(s) or legal representatives(s) to use and/or disclose protected health information in the manner described below. If I refuse to sign this authorization for the release of pertinent medical records, the City of San Diego may refuse to authorize workers' compensation benefits in my case.

AUTHORIZATION/USES: I hereby authorize you to disclose and/or photocopy to the City of San Diego, its agent(s) or legal representative(s) any and all medical records in your possession for the purposes of:

- **DETERMINING WORKERS' COMPENSATION BENEFITS**

The information to be disclosed includes, but is not limited to, chart notes, testing, billing, narrative reports, health questionnaires and all other medical records. A photostatic copy of this authorization shall be considered valid as the original.

Please list all doctors or medical facilities you have seen or treated with in the last ten years along with their addresses and phone numbers.

PHYSICIAN/MEDICAL FACILITY ADDRESS/PHONE NUMBER

DURATION: This authorization shall be valid for 12 months from the date this release is signed below.

REVOKING MY AUTHORIZATION: I understand that this authorization may be revoked in writing by the undersigned at any time by either writing the agent or legal representative of the City of San Diego who provided this form to me, or by asking that agent or legal representative of the City of San Diego to give me a form

to revoke the Authorization. If I revoke this authorization, I understand that the City of San Diego may refuse to authorize workers' compensation benefits in my case.

RESTRICTIONS: I understand that the City of San Diego may not further use or disclose the medical information received by this release unless another authorization is obtained from the undersigned or unless such use or disclosure is specifically required or permitted by law.

ADDITIONAL COPY: I further understand that I have the right to receive a copy of this authorization upon my request (Civil Code § 56.11).

I HAVE READ THE ABOVE LANGUAGE AND FULLY UNDERSTAND THE AUTHORIZATION BEING GIVEN TO THE CITY OF SAN DIEGO, ITS AGENT(S) AND/OR LEGAL REPRESENTATIVE(S) IN ITS ENTIRETY. I HAVE ASKED QUESTIONS ABOUT ANYTHING THAT WAS NOT CLEAR TO ME, AND I AM SATISFIED WITH THE ANSWERS I RECEIVED.

_____ DATED:

_____ PATIENT (PRINT)

_____ PATIENT SOCIAL SECURITY NUMBER

_____ PATIENT DATE OF BIRTH

_____ PATIENT SIGNATURE

_____ IF SIGNED BY OTHER THAN PATIENT, INDICATE RELATIONSHIP (LEGAL REPRESENTATIVE, PARENT, SPOUSE, GUARDIAN, RESPONSIBLE PARTY, ETC.)

Copy requested ☐ Yes ☐ No