AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PLEASE COMPLETE AND FAX BOTH PAGES OF THIS FORM TO SCRIPPS CLINIC 858-554-9901

Please read carefully. This consent authorizes Scripps Clinic to release relevant personal health information listed on the following page, for the purposes of conducting your upcoming WholePerson Examination™, to the Scripps Center for Executive Health:

9850 Genesee Avenue #520
La Jolla, CA 92037
(858) 626-4460
(858) 626-4465 (fax)

DURATION: I understand this authorization may be revoked in writing at any time, according to the instructions in the Scripps Notice of Privacy Practices, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization is valid for one year.

RESTRICTIONS: I understand that Scripps may not further use or disclose the medical information to an outside healthcare provider unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by laws I hereby release Scripps from any/all legal liability that may arise from the release of this information to the party named above.

ADDITIONAL COPY: I further understand that I have a right to receive a copy of this authorization upon my request.

Scripps

MRN: _____
Facility Use Only

Authorization: I authorize the release of information pertaining to my most recent executive physical for services rendered, or treatment, as described below for;

Name of Patient:_____ Date Of Birth: ____/____/____

Social Security Number: _____-_____-_____ Telephone: ( )_____

Record Holder: Scripps Clinic
10666 North Torrey Pines Rd. **La Jolla** **CA** **92037**
Street Address City State Zip

(858) 554-8545 (858) 554-9901
Phone Fax

Date of Service: From____/____/____ To ____/____/____

Location of Treatment: ☐ Inpatient ☐ Emergency ✓Outpatient

Type of Information: This authorization is limited to the following medical records and type of information:

- ✓ History/Physical Exam
- ✓ Treadmill/EKG
- ✓ Consultation Reports
- ✓ Dermatology Reports
- ✓ Laboratory Tests
- ✓ X-ray reports

☐ Other (please specify):_____

Special Categories of Information will not be released:
HIV (Human Immunodeficiency Virus) test results, Psychiatric records and Alcohol and/or drug abuse treatment records are not included in this authorization.

Use of Information: The requestor may use the medical records and type of information authorized for the following purposes and for any related follow-up care administered at Scripps Health:

✓ WholePerson Examination™

Printed Name:_____

Signature:_____ Date: _____