

Release of Information Request

I authorize PAMF to release my personal health information to me via PAMFOnline. I understand that due to California Health & Safety Code Section 123148, medical providers are prohibited from releasing the following laboratory results via PAMFOnline, even though a patient may consent to their release: "HIV antibody test; presence of antigens indicating a hepatitis infection; abusing the use of drugs; test results related to routinely processed tissues, including skin biopsies, Pap smear tests, products of conception, and bone marrow aspirations for morphological evaluation, if they reveal a malignancy." I understand that access to my health information is for my use only and that I may call PAMF for a more detailed explanation of laboratory test results received via PAMFOnline. I understand that I may revoke this authorization at any time in writing and that I have a right to receive a copy of this authorization upon request.

SIGNATURE: _____ **DATE:** _____

Enrollment Information

- You must be 18 or older to enroll.
- You must submit one form per enrollment request.
- A valid and functional e-mail address must be provided.
- Your user ID and password should not be shared with anyone.
- Use of PAMFOnline is for accessing your own health information.

Name _____

(please print legibly)

Today's Date _____ / _____ / _____

Date of Birth _____ / _____ / _____

SSN _____ - _____ - _____

E-mail _____

Mailing Address _____

City _____ State ____ ZIP _____

Phone _____

Receiving Your Access Code

Your access code will be mailed to you. Please allow one to two weeks for processing. **A missing signature will delay processing your request. Please ensure you have signed above.**

Check one box below:

- PAMFOnline (free)
- PAMFOnline Messaging - \$60 annual subscription fee
(You may pay for your subscription via the payment options listed below or subscribe online once you have established your account.)

Make checks payable to PAMF or provide credit card information below.

Name _____

(as it appears on card)

Card # _____

Card Type: VISA or MasterCard Exp. Date ____ / ____
(circle one)

Amount Due: **\$60**

Signature: _____

**Mail: Palo Alto Medical Foundation, PAMFOnline
PO Box 51477, Palo Alto, CA 94301-9877**

**Fax: Palo Alto Medical Foundation
Attn: PAMFOnline, (650) 565-4431**

If you would like a copy for your records, please photocopy this form.

For more information, go to our Web site at www.pamfonline.org.

How did you hear about PAMFOnline? Billing Insert Poster M.D./R.N. HealthNews Other _____