AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Information and Accountability Act (HIPAA) and California law, your individually identifiable health information may not be used or disclosed except as provided incur Notice of Privacy Practices without your authorization. Your completion of this form grants permission for the use and disclosure of your health information as described below. Please review and complete this form carefully. It may not be valid if not fully completed. Please note fees may apply for certain requests.

Patient Information:

Name: _____ Date of Birth: _____ Phone: _____

Address :_____

Health information to be disclosed (Please check one box): ☐ to ☐ from

Medical Practice or Provider Name:_____

Address :_____

Phone: _____ Fax: _____

The information you may release subject to this signed release form is as follows:

☐ Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Latermin-Peris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except specifically provided below.

☐ Pathology/Lab Reports ☐ Hospital/Consultation Reports ☐ Immunization Records

☐ Radiology Reports ☐ Operative Reports ☐ Visit Notes

☐ Medication Records ☐ Billing Reports

☐ Other: _____

Information to be released from the following dates:

☐ Any and all dates ☐ Past 2 years ☐ Past 5 years

☐ Other (please specify date range)_____

This information is to be disclosed (Please check one box): ☐ to ☐ from

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This information may be used for the following purposes (if you do not wish to explain the purpose, you may write “at the request of the individual”): _____

_____

I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form. This authorization is effective now and will remain in effect until 1 year from the date of signature.

I understand I have the right to receive a copy of this authorization.

Print Name: _____ Sign: _____

Date: _____ If not signed by patient indicate relationship: _____