AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL RECORDS

Completion of this document authorizes the disclosure and/or use of health information. This authorization complies with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq., and the Health Insurance Portability and Accountability Act (HIPPA).

TRANSMISSION OF INFORMATION;

FULL RECORDS (more than 10 pages) are transmitted by **MAIL ONLY**

LIMITED RECORDS (10 or less pages) can be transmitted by mail, fax or email

This request pertains to the release of medical information for the following PATIENT(S):

NAME: ____________________ DOB: ________ NAME: ____________________ DOB: ________

NAME: ____________________ DOB: ________ NAME: ____________________ DOB: ________

Information to be Released

☐ All Medical Records (**FULL RECORDS**)

☐ BILLING Records

☐ Mental Health; HIV/AIDS; Alcohol/Drugs

☐ Specific Dates(**LIMITED RECORDS**): ________

____

I authorize: ____________________

SENDER (Physician/Healthcare Facility)

To release records to: ____________________

RECIPIENT (Physician/Healthcare Facility)

Address: ____________________

Phone: ____________ *Fax:* ____________ *Email:* ____________

PURPOSE OF THIS REQUEST: ______Patient Request ______ Insurance Request ______ Legal _______ Other

1. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records as indicated above to include diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character. I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. To revoke an authorization I may fill out a revocation form available at the facility/Provider or write a letter to the facility/Provider. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

This authorization will expire 90 days from the date signed. A copy or facsimile of this authorization shall be counted true and valid as original. I have been advised of my right to receive a copy of this authorization.

____________________ ____________________ Date: ____________

(Signature of patient OR legal guardian) (Relationship if other than patient)

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