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) of 2003.

THIS REQUEST PRERTAINS TO THE RELEASE OF MEDICAL INFORMATION FOR THE FOLLOWING PATIENT(S):

NAME: _____DOB:_____ NAME: _____DOB: _____

NAME: _____DOB: _____NAME: _____DOB: _____

I AUTHORIZE:_____
SENDER (Physician/Healthcare Facility)

TO RELEASE RECORDS TO:_____
RECIPIENT (Patient/Parent/Legal Guardian OR Physician/Health Facility)

MAILING ADDRESS:_____

PHONE: _____ ***FAX:*** _____ ***EMAIL:*** _____

I SPECIFICALLY AUTHORIZE THE RELEASE/TRANSMISSION OF THE FOLLOWING INFORMATION(Check all that apply and initial):

_____ MENTAL HEALTH Initial _____
_____ HIV Initial _____
_____ ALCOHOL/DRUGS Initial _____

_____BILLING RECORDS
_____ FULL RECORDS (TYPE: consults, labs, test results, history & physical, progress notes)
_____ PARTIAL RECORDS (specific dates/ type of record)

- List Dates/Type: _____

PLEASE TRANSMIT MY RECORDS BY: ____*FAX* ____*EMAIL* ____ *MAIL* (***Records more than 10 pages are sent by MAIL only)***

PURPOSE OF THIS REQUEST: _____ Insurance Request _____ Legal _____Changing Physicians _____Other

Records copy fee= $25.00* ****There is NO CHARGE to send records directly to a PHYSICIAN/ HEALTH FACILITY*

This Authorization will expire in 6 months from the signature date. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records as indicated above. I understand I have the right to revoke this authorization at any time by giving a written request to the facility/provider. I understand the revocation will not apply to information that has already been released in response to this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-discloser is in some cases not protected by California law and may longer be protected by Federal confidentiality law (HIPAA). 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 Parent/legal guardian) (PRINTED NAME)

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