AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION PURSUANT TO EVIDENCE CODE SECTION 1158

The undersigned authorizes the medical provider designated below to disclose specified medical records to a designated recipient. The medical provider shall not condition treatment, payment, enrollment, or eligibility for benefits on the submission of this authorization.

Patient Information

Patient Name: ______________________________

Medical Provider: ______________________________

Medical Record Number: ______________________________

Date of Birth: ______________________________

Address: ______________________________

Telephone Number: ______________________________

Email: ______________________________

Authorized Recipient Name: ______________________________

Recipient Address: ______________________________

Recipient Telephone: ______________________________

Recipient Email: ______________________________

Health Information Requested (*check all that apply*)

☐ All records

☐ Records dated from ______________ to ______________

☐ Laboratory Results dated from ______________ to ______________

☐ Radiology records: ☐ images or films
☐ reports
☐ digital/CD, if available.

☐Laboratory results regarding specific test(s) only (*specify*):

____

☐ Records related to a specific injury, treatment, or other purpose (*specify*):

____

Note: records may include information related to mental health, alcohol or drug use, and HIV or AIDS. However, treatment records from mental health and alcohol or drug departments and results of HIV tests will not be disclosed unless specifically requested (*check all that apply*):

☐ Mental health records

☐ Alcohol or drug records

☐ HIV test results

Preferred method of delivery of requested records:

☐ Mail

☐ Pick up

☐ Electronic delivery, recipient email: ______________________________

This authorization is effective for one year from the date of the signature unless a different date is specified here: ____________

This authorization may be revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request.

A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization.

Notice: Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient signature*: ____

Date: ____________

Print name: ____

If not signed by the patient, please indicate relationship to the patient (check one, if applicable):

☐ Parent or guardian of minor patient who could not have consented to health care

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient