

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: _____

Recipient Fax: _____

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