AUTHORIZATION FOR THE RELEASE OF INFORMATION

This meets the requirements of the HIPAA Privacy Rule including CA Civil Code 56.10 & 56.11, 45 CFR 164.508 & 164.512 and CA Evidence Code 1158.

To: ____

(entities from which the undersigned authorizes release of information

This will authorize you to permit ______________________________

(your firm name)

or their agent:

to review, inspect, copy and/or photocopy any and all of the following records which are in your possession and/or control :

☐ **MEDICAL RECORDS**

which can include x-rays & readings, films, hospital & laboratory tests, reports, charts, graphs & notes, all industrial & non-industrial records, in-patient & out-patient charts and billing records.

☐ **PSYCHIATRIC/DRUG/ALCOHOL/HIV RECORDS**

which can include reports of psychological testing & the actual test papers/materials.

☐ **PERSONNEL/EMPLOYMENT RECORDS**

which can include application, attendance, payroll, incident reports, pre-employment exam records and employee progress records.

☐ **INSURANCE RECORDS**

which can include medical records, correspondence, payments, claims, applications and policies.

Claim #:________________________ Insured:________________________

Date of Loss:____________________

☐ **POLICE RECORDS**

which can include arrest reports, traffic accidents or victim reports.

☐ **OTHER**

which can include: ____

This information is to be used or disclosed for the following purpose:

____

I understand that I have the following rights with respect to this authorization:

The recipient of the protected information is prohibited from redisclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required by law.

I may not be required to sign this authorization as a condition to obtaining treatment, payment or eligibility for benefits.

I am entitled to a copy of this authorization. A copy of this authorization shall be considered as valid as the original.

I have a right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing & present my written revocation to the facility where records have been requested.

I am entitled to notification if the custodian of records will use or disclose the information for marketing & receive payment for the use or disclosure of my information.

This authorization will expire on:___________________

Dated:________________

Patient Signature:__________________________________
Printed Name:_____________________________________
AKA:____

Date of Birth:______________________________________
Social Security Number:_____________________________