HIPAA MEDICAL RECORDS AUTHORIZATION
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: **Health Record #:**

Date of Birth: **SSN:**

1. I authorize the use or disclosure of the above-named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:
   Facility:
   Address

   Phone:

3. You are hereby authorized to furnish to **Medical Records Now**, 228 Calle Bolero, Oceanside, CA 92057 and / or their representative, information concerning my examination, diagnosis, and treatment as well as a photocopy of my complete health record and complete billing records, including, but not limited to, problem list, medication list, patient registration and information forms, pertinent documentation, history and physical, discharge summary, photographs, videotapes, operative reports, consultation reports, x-ray & imaging reports, lab results, progress notes, EKG, EEG, office notes, and x-ray films / images.
4. I understand that the information in my health records may include information relating to sexually transmitted disease, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. I understand I have the right to revoke this authorization at anytime. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in one year.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand my disclosure of information may not be protected by federal confidentiality rules. I understand once health information is disclosed it may be released to others and may not be protected by HIPAA.
7. A copy of this authorization is as valid as the original. Member / Patient has a right to a copy of this authorization.

_____ _____
Signature of Patient of Legal Representative Relationship to Patient

_____ _____
Print name Date signed