Authorization for Release of Protected Health and/or Personal Information

1. Authorization: I authorize disclosure of Protected Health and/or Personal Information as described below:

Name of Patient:_______________________________ Date of Birth____________

Patient Address: ____

Social Security Number:_____-____-_____ Phone (____)___________________

2. Record Holder:____
(Name of Location holding Records / Disclosing Party)

____
Street Address City State Zip

3. Records May Be Released To:____________________C/O CD Photocopy Service, Inc
(Name of Requesting Party and/or Agent)

___17371 Irvine Blvd.,______________Tustin,_____________________CA______92780____
Street Address City State Zip

4. Type of Information: This authorization allows for the release/disclosure of records pertaining to, but not limited to: Any and all medical records, files, reports, charts, graphs, notes, tests, MRI's, X-Rays, lab reports, billing, Employment, Scholastic, Union records, personnel, attendance, pension, transcripts, wage and insurance information, earnings and employment from Social Security Administration, EDD Disability and Unemployment records, Insurance and Claim records, Police, Prison and Probation records, unless otherwise listed below.

____Other (Please Specify)____

Specific Confidential Records Release/Disclosure: Please mark all that apply

____Genetic Records ____Treatment for Alcohol and/or Drug Abuse

____HIV Test Results ____Psychiatric / Mental Health Records

____Other (Please Specify)____

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5. Date Range/Treatment Dates: Unless specified below, Patient is uncertain of specific treatment dates and/or is approving release of any and all records in possession of the Record Holder cited above: **From** _________ **To** _________

6. Use of Information: The individual or entity identified above is permitted to use my information for the following purposes: **Please mark all that apply**

___Transfer of Care ___Second Opinion ___Personal _X_Insurance ___Legal

___Continuing of Care _X_Other (please specify)_for Workers Compensation Claim_______

7. Duration: This Authorization is valid for one year from the date next to my signature, unless otherwise noted here:___________________________________

8. Additional Copy: I further understand that I have a right to receive a copy of this authorization upon my request.

9. Redisclosure: I understand that once received, my records will be subject to re-disclosure and may no longer be protected by federal privacy laws.

10: Revocation: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requester is specifically required or permitted by law.

11. Explanation: I understand that my treatment is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.

12. Signature:
Printed
Name:____

Signature:_________________________________Date/Time:________________

If other than patient, indicate relationship to patient: ________________________

For your protection California law requires the following to appear on this form: Any person knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.