AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of patient: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: _____to release to:

_____

(*Persons/Organizations authorized to receive the information)*

_____

(*Address----street, city, state, zip code*

The following information:

☐ All health information pertaining to my medical history, mental or physical condition and treatment received; OR

☐ Only the following records or types of health information (including any dates)

_____

_____

PURPOSE

Purpose of requested use or disclosure: ☐ Patient Request; OR ☐ Other:

_____

_____

_____

EXPIRATION

This authorization expires on (date): _____

MY RIGHTS

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must also do so in writing and submit it to the following address: 653 Camino De Los Mares #109, San Clemente, CA 92673.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

SIGNATURE

Date: _____ Time: _____ AM ☐ PM ☐

Signature: _____

(Patient/ legal representative)

If signed by a person other than the patient, indicate relationship: _____

Print name: _____

(Patient/ legal representative)