Internal Medicine/Family Medicine/Hospital Medicine

AUTHORIZATION FOR RELEASE OF PATIENT-IDENTIFIABLE

HEALTH INFORMATION

Patient Name: _____Medical Record # _____
Date of Birth: _____
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: Unified Health Associates
1206 W Ave J Ste.100
Lancaster Ca. 93534

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).
/ / Progress Notes
/ / Laboratory Reports from _____ to _____
/ / Radiology Reports/Imaging Reports from _____ to _____
/ / Consultation Reports from (Dr's name) _____
/ / Immunization Records
/ / Procedure, & Pathology Report, if any, from (Date) _____
/ / Any and All records
Other:
_____
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired. immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.
5. This information may be disclosed to and used by the following individual or organization:

Unified Health Associates
1206 W Ave J Ste. Lancaster Ca. 93534

For the purpose of
_____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my

insurance company when the law provides my insurer with the right to contest a claim under my policy.
Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date on which it was signed.
7. 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 that I may inspect and/or receive a copy of the information to be used or disclosed, as provided in CFR 164.524, and that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Date _____ Identity verified by Photo/ID

Patient/Legal Representative Signature (Circle One)

_____

Signature of person releasing records

1206 West Avenue J, Unit 100, Lancaster, CA 93534
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