Unified Health Associates

Internal Medicine/Family Medicine/Hospital Medicine

AUTHORIZATION FOR RELEASE OF PATIENT

IDENTIFIABLE HEALTH INFORMATION

Patient Name:

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:

Individual/Org: Unified Health Associates

Address: 1206 W Ave J Ste. 100 Lancaster Ca. 93534

Phone: 661-952-5555

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

/ / Progress Notes

/ / Reproductive Care (to include contraception, abortion or abortion related care)

/ / Gender Affirming Care

/ / 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

Internal Medicine/Family Medicine/Hospital Medicine

Individual:

Address:

Phone:

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 done 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. **Date:**

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.

If I have questions about disclosure of my health information, I can contact the Privacy Officer at (661)952-5555.

_____ 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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