AUTHORIZATION FOR RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION

Patient Name: _________________________ DOB: ___________________
Address: ________________________________
City ___________________ State ____ Zip _______ Phone #: _______________

I hereby authorize: AV Pediatrics, Allergy & Family Medicine
1523 West Avenue J #7
Lancaster, CA 93534
661-945-2221 Ext. 201 Fax: 661-729-8234

To Release my Records to:

____
Provider, Facility or Individual Name

____
Address

____
Phone Number Fax Number

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

__ Progress Notes from __________ to __________
__ Lab Reports from __________ to __________
__ Radiology Reports from __________ to __________
__ Consultation Reports Dr. ________________________
__ Immunization Records
__ Proc/Op & Pathology from __________ to ___________
__ Any and All records
__Other:____
____

*Please see reverse side for additional instructions

Patient's Name: ____

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.

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 of condition ________________. If I fail to specify an expiration date, this authorization will expire six months from the date on which it was signed. This authorization covers only the records and time period(s) specified above.

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 or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (661) 945-2221 and request to speak with the HIPAA Privacy, Security & Compliance Officer.

____
Signature of Patient/Legal Rep.
(Specify relationship if Legal Rep.)

Date: ___________________

____
Relationship to Patient

Identity verified by Photo ID

____
ID type Exp. of ID

Released by: