Authorization to Release Protected Health Information

HIPAA Compliant Request for Information

Name of Patient _____ Street Address _____

Phone Number _____ Fax Number _____ City _____ State _____ Zip Code _____

Email Address (please be sure to print clearly) _____ Date of Birth (00/00/0000) _____

I hereby give the following entity permission to release my Protected Health Information (PHI) to:

Newport Family Podiatry
355 Placentia Ave, Suite 302
Newport Beach, CA 92663

☐ Michael J. Hattan D.P.M. ☐ Arthur A. Walton D.P.M.

I instruct Newport Family Podiatry to produce the following information: (Check ONE only)

☐ Release a 2 year abstract of my records
☐ Entire Record (Any payments are required prior to release)
☐ I would like specific records released (X-Rays, Lab Results, Medication List):

_____

I authorize the above listed records to be released to the following entity:

☐ Provider ☐ Insurance ☐ Patient

Name _____ Street Address _____

Phone Number _____ Fax Number _____ City _____ State _____ Zip Code _____

This authorization expires ninety (90) days from signature, or at the following event:

_____

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I am requesting my PHI to be disclosed for the following purpose:

□ Continuing Care □ Change of Insurance □ Referral

□ Other: _____

HIV, Behavioral Health, or Drug and Alcohol Abuse/Treatment information contained within the dates of service I have specified above *are to be released through this authorization* unless specified below:

DO NOT RELEASE: (Circle all that apply) HIV Behavioral Health Drug/Alcohol

I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosure the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may not longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

_____ _____

Print Name Signature of Patient Date

_____ _____

Signature of Parent/Guardian or Personal Representative (attach proper documentation) Date

_____ _____

Signature of Witness Date