AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Meets Cal. Civil Code §56.11 and 45 CFR§164.508 Requirements

Patient's Name _____ Also Known As _____ Date Of Birth _____

Social Security Number _____ Email Address- Records will be provided on PDF format, please provide email address. _____

Address, City State, Zip Code _____ Phone Number _____

I authorize the below name facility to disclose a copy of my health information.

Facility Name _____ Doctor's Name _____

Address, City State, Zip Code _____ Phone Number _____

I authorize the facility or doctor listed above to my release protected health information to Records Source.

By initialing here, I authorize:

_____ **All Health Information**

_____ **Billing Records Information**

_____ **X-Rays Records**

_____ **SDT/HIV/AIDS**

_____ **Alcohol or Drug treatment Information**

_____ **Dates of Service**_____.

_____ **Other**_____.

I may revoke this authorization at any time, but I must do so in writing and submit it to the facility or doctor holding the records as listed on this form. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

Records Source
1142 S. Diamond Bar Ste 310, Diamond Bar CA 91765
Tel: 909-271-3050 Fax: 888-850-5101
support@recordssource.com
www.recordssource.com

Purposes for which the information will be used or disclosed.

_____	Personal (at request of patient)	_____	New Physician
_____	Primary Care Physician	_____	Social Security Disability
_____	Medical Insurance Claim	_____	Life Insurance
_____	Workers' Comp Attorney	_____	Other_____

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I have a right to receive a copy of this authorization.

This Authorization will expire upon its completion or 12 months from date of signature, whichever comes first.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by state law and may no longer be protected by federal confidentiality law (HIPAA).

_____	_____
Patient's Name	Patient's Signature
_____	_____
Legal Guardian Name	Legal Guardian signature
_____	_____
Date	Date

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CHECK THE STATUS OF YOUR REQUEST FOR RECORDS

www.recordssource.com/status