HIPAA MEDICAL RECORDS RELEASE FORM

Medical Provider: _____

_____

Regarding: _____ DOB:_____ SSN:_____

You are hereby authorized **to provide to Los Angeles Records Service**, 10073 Valley View St., Ste. 221, Cypress, CA 90630, a representative of

_____,
(firm name, address)

any and all information regarding treatment for all physical or mental health conditions rendered to me. This includes any and all records, including any records stored electronically, concerning medical history, care, treatment, diagnosis, prognosis, medications, billing, insurance records, color photographs, imaging breakdown including x-ray, CT & MRI films (including dates, parts of the body & number of films), evaluations, examinations, physiotherapy, pathology reports and slides, and all other diagnostic tests and procedures, including but not limited to, all records for each and every visit, examination and/or treatment, including all dates and the charges made thereof, unless otherwise specified below:

_____
(date range, specific records)

I understand that the information in my records may contain information relating to the treatment of HIV/AIDS, sexually transmitted disease, mental health condition and treatment, or drug and/or alcohol abuse. I authorize this information to be disclosed.

This authorization is being executed by the patient, or patient's representative, **for** medical/legal review. I am **entitled to a copy** of this authorization and to copy or inspect the information to be disclosed. I understand that there is a potential for the **re-disclosure** of the information released, and such re-disclosure may not be protected by federal confidentiality rules.

I have the **right to revoke** this release authorization at any time. I understand that should I choose to revoke this authorization, I must do so in writing and present my revocation to the facility and law firm listed above. Furthermore, the revocation will not apply to the records or information that has already been released in response to this authorization. Unless revoked, this authorization will **expire** 1 year from the date below.

I understand that **treatment**, payment, enrollment, or eligibility for benefits **may not be conditioned** upon my signing of this authorization. I may refuse to sign this authorization.

Copies of this authorization are as **valid as the original** and may be used in lieu of the original.

_____ _____

(Date) (Name)

_____ _____

(Relationship to Patient) (Signature of Patient/Legal Representative)

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