AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize_____
(NAME OF PHYSICIAN OR HEALTHCARE PROVIDER AUTHORIZED TO USE OR DISCLOSE INFORMATION)

At the request of the undersigned individual, the provider designated above is authorized to disclose specified medical records to the representative of _____ for legal discovery. _____ is authorized
(Applicant Name) (Copy Service)
by the patient and/or the patient's representative and/or the patient's attorney to receive information pertaining to:

Patient Name: _____ **AKA:** _____
Date of Birth: _____ **SSN**: _____
Representing Attorney: _____
Deliver to: _____
(Name) (Address) (Phone)

Health Information Requested:
The provider is required to make available for copying any and all records (both electronic and hand written) pertaining to the individual listed above including but not limited to intake forms/sheets, treatment, hospitalizations, evaluations, testing, consultation reports, progress notes, laboratory and pathology reports, radiology/imaging reports, immunization records, and surgeries. This includes all files or records for all injuries or conditions in the Provider's possession or under the Provider's control for any purpose. Nothing shall be removed, deleted, altered or withheld.

Additional information to be disclosed by the Provider if box is checked (check all that apply):

- ☐ Physical X-Rays, MRIs, CT Scans
- ☐ Alcohol/Drug Testing/Evaluation/Treatment Records
- ☐ All billing charges, expenses, costs and payments
- ☐ HIV/AIDS/STD Testing/Evaluation/Treatment
- ☐ Psyche, mental, psychiatric, psychological, psychotherapeutic
- ☐ Employment, Personnel, Attendance, Wage, Injuries, Claims, Disciplinary and Human Resource Records

Revocation: This authorization may be revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request. Revocation must be submitted to the facility. A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization. The medical provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization.

Note: Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Expiration: This authorization is effective for three years from the date of the signature unless different dates are specified here: _____.

Electronic Signature: The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

_____ _____
(Signature of patient, patient representative, or attorney) Date

_____ _____
(**If signed by someone other than patient, indicate relationship**) **Date**

Required by Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164; pursuant to Evidence Code section 1158