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 in PDF format.

______________________ 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 the following protected health information.

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**____.

Fax: 888-850-5101
request@retrievalsupport.com

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.

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 COMPETITION OR THREE MONTHS FROM THE 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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