AUTHORIZATION FOR USE AND / OR DISCLOSURE OF MEDICAL INFORMATION (14 pt / HIPAA Compliant)

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

I hereby authorize the physicians and / or employees of:

FACILITY: _____
ADDRESS: _____

to release information as indicated below. Release records and information regarding:

_____
Name of Patient (List Any AKA's)

_____
Address Telephone Number

_____ _____
Social Security Number Date Of Birth

Release Medical Information To: _____

c/o Kopy Kat Litigation Support Services
400 Atlas Street
Brea, CA 92822
714-990-6100 / Fax 714-990-6126

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one (1) year from the date of signature if no date entered.

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the requestor may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

SPECIFY RECORDS: Check the box and initial which type of information is to be disclosed:

☐ MEDICAL INFORMATION

☐ PSYCHIATRIC INFORMATION

_____ _____
Signature Date

☐ DRUG / ALCOHOL

☐ HIV TEST RESULTS

_____ _____ _____ _____
Signature Date Signature Date

☐ EMPLOYMENT / PERSONNEL

☐ OTHER (specific): _____

_____

I request that the health information released pursuant to this authorization be used for the following purposes only:

_____

A copy of this authorization is as valid as an original. I understand I have the right to receive a copy of this authorization. The copy is for me to keep

_____ _____
Date Signature of patient or patient's Representative

_____
Indicate Relationship (if signed by Other than Patient

_____
Witness (If required)