

**AUTHORIZATION FOR USE AND / OR DISCLOSURE
OF 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.

REDISCLASURE:

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.

“ (ii) The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization, by stating either: (A) The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations in paragraph (b)(4) of this section applies; or (B) The consequences to the individual of a refusal to sign the authorization when, in accordance with paragraph (b)(4) of this section, the covered entity can condition treatment, enrollment in the health plan, or eligibility for benefits on failure to obtain such authorization. “

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)