AUTHORIZATION FOR RELEASE OF

PATIENT MEDICAL AND/OR BILLING RECORDS

HIPAA COMPLIANT AUTHORIZATION FORM

I authorize _____ to release health information to:
(name of person or facility which has information)

_____
Name of person or facility to receive health information

_____
Specify name/title of person to receive health information, if known / Telephone #

_____
Street Address, City, State, Zip Code

Please specify the health information you authorize to be released:

☐ **MEDICAL RECORDS** ☐ **MEDICAL BILLS**

Type(s) of health information: _____
Date(s) of treatment: _____

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).

☐ I specifically authorize the release of HIV/AIDS test results (Health and Safety Code §120980(g)).

☐ I specifically authorize the release of genetic testing information (Health and Safety Code §124980(j)).

The purpose of this release is for (check one or more):
☐ At the request of the patient/patient representative
☐ Other (state reason) _____

NOTICE
Hospitals, medical facilities and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS
This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to
THE BONAR LAW GROUP
1 Centerpointe Dr. Suite #100 | La Palma, CA 90623
Telephone: (714) 452-1428 | Fax Line: (714) 452-1418.
The revocation will take effect when THE BONAR LAW GROUP receives it, except to the extent THE BONAR LAW GROUP or others have already relied on it.

You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION
Unless otherwise revoked, this Authorization expires _____(insert applicable date or event). ***If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.***

_____ _____
Print Name Signature (Patient, Parent, Guardian)

_____ _____
Date Time Relationship to Patient (Parent, Guardian, Conservator, Patient Representative)

_____
Witness (only if patient unable to sign)