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@statussupport.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)

_____ Primary Care Physician

_____ Medical Insurance Claim

_____ Workers' Comp Attorney

_____ New Physician

_____ Social Security Disability

_____ Life Insurance

_____ 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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