Authorization for the Release of Protected Health Information

Patient Name: ________________________________ DOB: _______________________

Note: Any requests for records to a person/organization other than a health care facility or insurance company, to obtain health care services or insurance coverage is subject to a fee of 1-35 pages = $35, 36-50 pages = $50, and 51-75 pages = $75.

I authorize the release and disclosure of my Protected Health Information between Dr. Paul Valbuena and his staff and:

Person/Organization:
____

Street: _______________________City: ____________________State: _______________ Zip: _____________ Phone: ____ Fax: ____________________________________

( ) Release my Records ( ) Obtain Records

The type and amount of information to be used or disclosed is:

____ All Records ____ Lab Results ____ Treatment/Visit Notes ____ Imaging Results ____ Medication List ____ Test Results ____ Discharge Summary ____ Other: ____

I understand that my Protected Health Information may contain information relating to Sexually Transmitted Diseases, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, treatment of alcohol/ drug abuse and genetic testing.

I understand that the information released may no longer be protected by state and federal regulations and may be re-disclosed by the recipient of the information.

I understand that I may revoke this authorization, in writing to Dr. Valbuena, except to the extent that action has already been taken according to the authorization.

I understand that the authorization will expire 1 year from the date signed, if not revoked, or as specified.

I release Dr. Paul Valbuena and his staff from any legal liability for the release of information in accordance to the above authorization.

________________________________ ______________________________ ______________________

Signature Printed Name Date

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