



PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH CARE INFORMATION

Patient's Name *(Please Print)*: _____

Date of Birth: _____ SSN: _____

I request and authorize South Strand Internists & Urgent Care to release Health Care Information of the patient named above to:

Medical Facility/Doctor: _____

Phone #: _____ Fax #: _____

Address: _____

City, State, Zip: _____

This request and authorization applies to:

All Health Care Information

Only Health Care Information relating to the following treatment, condition, or dates of treatment:

Other *(Please Specify)*: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Medical Records department. I know that revoking this authorization would not prohibit any release of information by South Strand Internists & Urgent Care in reliance on my original authorization.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by the regulations.

If this authorization was given as a condition of obtaining insurance coverage, the insurance company has the right to contest a claim made under the insurance policy.

This authorization expires 7 years after date signed.

Patient/Representative Signature: _____ Date _____

Representative Name *(Please Print)*: _____

Relationship to Patient: Parent Legal Guardian Other *(Please Specify)* _____