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.

I understand that there may be fees associated with this request.

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)* ______________

(Revised: October 23, 2018)

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