Authorization for Release of Information

I authorize _____
(name of physician or health care provider authorized to use or disclose information)

The below signed patient, parent, and/or the patient's personal or legal representative hereby requests and directs you by the authority of the confidentiality of the Medical Information Act, Welfare and Institution Code Sections 5328 and 42 CFR 2.3, et seq., Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.F 164, to release the information described below to a representative of Real Imaging is authorized by the patient and/or the patient's representative and the patient's attorney to receive this information pertaining to:

Patient / Employee: _____

AKA: _____

Social Security No: _____ Date of Birth: _____

For the purpose of: aiding the patient or patient's attorney in determining the nature and extent of a claim for injuries and disabilities and to establish the liability for benefits, expenses, compensation and damages.

This information is limited to the following type and amount of information. (Any and All Information unless otherwise specified by type and dates where appropriate)

- ☒ Any and all Medical Records ☐ for the last _____ years
- ☒ Consultation Reports ☐ Patient Billing Information
- ☒ Progress Notes ☐ Immunization Records
- ☒ Laboratory, Pathology Reports from _____ to _____
- ☒ Radiology / Imaging Reports from _____ to _____
- ☒ Actual X-Rays, MRI's, CT Scans from _____ to _____
- ☒ Personnel & Wage Records
- ☐ Other:

Initials/Consent _____

This authorization conforms to California Civil Code Section 56.11 and 164.508 – pg. 82811 of the Federal Register, Dec. 28, 2000; California Welfare and Institutions Code Sections 5328, 42 CFR 2.31, and all Health Information Portability and Accountability Act of 1996 (HIPAA) 45 C.F.F 164 requirements.

DISCLOSURE REQUIRING SPECIAL CONSENT

My signature below specifically authorizes the release of healthcare information relating to the testing, Diagnosis or treatment for *(initial appropriate areas)*:

HIV/AIDS virus _____ Mental Health/Psychiatric Disorders _____

Sexually Transmitted Diseases _____

Drug, Alcohol Abuse/Treatment _____

Right to Revoke: I understand that I have a right to revoke this authorization at any time. I understand that my revocation must be in writing and present to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date event or condition:

Expiration: If a specific expiration or event is not provided, this authorization shall remain valid for a period of **one year** from the date signed and **a copy of this authorization is as valid as the original**. An original authorization is not required to be shown.

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information. I understand I have a right to receive a copy of this authorization.

_____ _____

(Signature of patient, parent and/or legal guardian) *Date*

_____ _____

(If signed by other than patient, indicate relationship) *Date*

This authorization conforms to California Civil Code Section 56.11 and 164.508 – pg. 82811 of the Federal Register, Dec. 28, 2000; California Welfare and Institutions Code Sections 5328, 42 CFR 2.31, and all Health Information Portability and Accountability Act of 1996 (HIPAA) 45 C.F.F 164 requirements.