AUTHORIZATION TO RELEASE MEDICAL RECORDS

(This authorization complies with HIPAA)

Print Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)

Address (Street Address, Town, State, Zip Code)

Phone Number	E-mail

Print Name of Guardian or Legal Representative if Applicable (first, middle, last name)

Address (Street Address, Town, State, Zip Code)

Phone Number	E-mail

Relationship & Authority (parent, legal guardian, personal representative, etc.)

I. <u>My Authorization</u>

I hereby authorize Catherine Cox, M.D., 711 D Street, Suite 102, San Rafael, CA 94901, phone (415) 578-0127, fax (888) 415-4939, to disclose the following health care information about me:

☐ All my health information maintained by you

☐ My health information relating to this treatment or condition: _____

☐ My health information for the dates from: _____ to _____

☐ Other: _____

You may disclose this health information to:

Person/Organization to Receive Information

Street Address

City	State	Zip Code

Phone Number	Fax Number

Continued

AUTHORIZATION TO RELEASE MEDICAL RECORDS, continued

Reason(s) for this authorization (check all that apply):

☐ At My Request ☐ Change of Doctor ☐ Specialist Referral
☐ Workers Compensation ☐ Insurance Purposes ☐ Continued Treatment
☐ Legal Investigation ☐ Other:_____

This authorization (check one):

☐ Is valid for 24 months following the date of my signature below
☐ Ends on (date) _____ following the date of my signature below
☐ When the following event occurs: _____

II. <u>My Rights</u>

I have the right to revoke this authorization at any time, in writing, sent to: Catherine Cox, M.D., 211 D. Street, San Rafael, CA 94901. If I do, it will not affect any actions already taken by Catherine Cox, M.D., based upon this authorization; uses and disclosures already made cannot be taken back. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information. I may not be able to revoke this authorization if its purpose was to obtain insurance.

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled a copy of this authorization after I have signed it. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original.

Signature of Patient or Legally Authorized Representative	Date Signed

Print Name of Representative if Signed on Behalf of the Patient

Patient is unable to sign because of (age of minor or reason for patient's inability to sign):
