PROFESSIONAL
Medical Copy

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Authorization to Release Protected Health Information

Completion of the document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

Patients Name _____
Please Print Full Name

Phone _____ Email _____

Other Names Used _____ Date of Birth _____

Social Security Number _____

Current Address _____
Street, City, State, Zip Code

I hearby authorize _____ and/or their agents, Professional Medical Copy to review, make copies of and release my medical information to:

_____
Persons/Organizations authorized to receive information

_____
Persons/Organizations Street, City, State, Zip Code

Information to be Released

The type of information to be released includes the following (please check applicable boxes):

☐ Last 6 months of treatment (beginning from last visit)

☐ Last year of treatment (beginning from last visit)

☐ Entire Record (including Paper & Electronic Records)

☐ Other _____
List and Specific Dates

I hearby consent to the release of all alcohol and/or drug abuse information relating to sexually transmitted disease, acquired Immunodeficiency Syndrome (AIDS), human Immunodeficiency Virus (HIV), or psychiatric treatment records under the same conditions outlined above.

I understand that such information cannot be released without my specific consent.

Signed _____ **Date** _____

Notice of Rights and Other Information

- I understand the authorizing release of this information is voluntary. If I refuse to sign this authorization, the requested information will not be released.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me (or a legal representative), and delivered 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.
- Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that if I fail to specify an expiration date, event or condition, this authorization will expire in one year from date of execution.
- I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.
- I will be given a copy of this authorization form if I request it.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by the federal law. However, California law prohibits the person receiving health information from further release without authorization unless required or permitted by law.

Signed _____ **Date** _____

I am aware that Professional Medical Copy is a confidential correspondence copy service contracted by the physician and/or facility, and through their service my records request will be processed and delivered as instructed. Professional Medical Copy abides by the guidelines of Health Insurance Portability and Accountability Act (HIPAA) and the protection of Protected Health Information (PHI), records are invoiced pursuant to 45 CFR 164.524 - Access of Individuals to Protected Health Information.

- I understand that all costs for requests will be invoiced at a cost base rate.
- I understand that Professional Medical Copy will invoice me for this service and agree to pay for their services.
- I understand by signing below I acknowledge the above charges and my acceptance of the personal financial responsibility.
- I understand that expanded dates or additional request for other providers will be subject to additional charges.
- I understand that invoices not paid within 30 days are subject to a $15° Late Payment Fee and Finance Charges at the rate of 18% APR.

Signed _____ **Date** _____