enLiven MEDICAL CLINIC

AUTHORIZATION for USE or DISCLOSURE of HEALTH INFORMATION (RECORDS RELEASE)

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

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Name of Patient:_____**Date of Birth**: _____

I hereby authorize Enliven Medical Clinic, Dr Mozhan Ashtari to release my records **TO**:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ FAX: _____

WHAT RECORDS TO SEND?

Records From: _____ To: _____ *If no dates are entered only the last 2 years are being requested.

Please send the following types of records:

□ All health information pertaining to any medical history, physical condition, and treatment received. **OR**

Exclusively the following: □ Labs □ History and Physical □ Progress Notes □ Consult Notes □ Other: _____

AUTHORIZATION TO RELEASE STATUTORILY PROTECTED INFORMATION:

I specifically authorize release of the following information (check and initial as appropriate):

□ Mental health treatment information Initial if releasing: _____

□ HIV test results Initial if releasing: _____

□ Alcohol/drug treatment information Initial if releasing: _____

WHAT IS THE PURPOSE OF RELEASING THESE RECORDS?

□ Continuing Care □ Patient Request □Legal □ Insurance □ Other: _____

***If no box is checked; this will be treated as a continuing care request.**

This Authorization expires [insert date]:_____ *If no Date is given, this authorization will expire 6 months from the signature date.

WHAT ARE MY RIGHTS?

- I may refuse to sign this Authorization. If I refuse to sign this Authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to Enliven Medical Clinic. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.
- I have a right to receive a copy of this Authorization. Copy requested and received: Initial: _____ Date:_____
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re- disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

Patient Signature: _____**Date:**_____

THIS SECTION MUST BE FILLED OUT IF THE PATIENT DID NOT SIGN ABOVE:

Legal Representative Signature:_____ **Date:** _____

State your legal relationship to the patient and why you have authority to act for the patient. (**The legal representative must submit proof of legal representation.)** _____

WitnessSignature:_____Date:_____