RICHARD L. MALINICK, M.D.

1125 Via Verde Ave. San Dimas, CA 91773 909-592-8170

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Print in ink * Failure to provide all information may invalidate this authorization.

**Substance Abuse Records and Psychiatric Records require a separate authorization.*

PATIENT INFORMATION

Patient Name: Last _____First_____ MI_____

Date of Birth_____ SSN _____ Phone ( ) _____

Address_____City_____State _____Zip_____

☐ **I AUTHORIZE RICHARD L. MALINICK, M.D. TO RELEASE MEDICAL RECORDS TO:**

Person/Organization_____

Address_____City_____State_____Zip_____

Phone ( )_____ FAX ( )_____

☐ **I AUTHORIZE RICHARD L. MALINICK, M.D. TO REQUEST MEDICAL RECORDS FROM:**

Person/Organization_____

Address_____City_____State_____Zip_____

Phone ( )_____ FAX ( )_____

INFORMATION TO BE RELEASED

Dates of Treatment _____

☐ Clinical Notes

☐ I specifically authorize release of HIV results

☐ X-rays, *specify*_____

☐ Billing Summary, *Dates of treatment*_____

☐ Labs/Tests, *type* _____ _____

☐ Other, *specify*_____

PURPOSE/REASON RECORDS ARE TO BE DISCLOSED

☐Continued Care

☐Insurance (fee applies)

☐Personal Use (fee applies)

☐Legal (fee applies)

☐Other, specify_____

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NOTICE OF RIGHTS

Voluntary: I understand authorizing the disclosure of the information identified on the first page is voluntary. I need not sign this form to ensure healthcare treatment.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Office of Richard L. Malinick, M.D. The revocation will take effect upon receipt. 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.

Expiration: This authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified: _____

Right to Inspect: I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524 and that I have a right to a copy of this form.

Redisclosure: I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I release Richard L. Malinick, M.D. and employees of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

Questions: If I have questions about disclosure of my health information, I can contact the Administrator at the Office of Richard L. Malinick, M.D.

Copies or Transfers: I understand that per *California Law (AB610)* you may charge me a reasonable charge of $0.25 per page, plus postage and any reasonable clerical costs incurred in making the records available. I further understand that you may charge me your reasonable actual costs for providing copies of any x-rays.
***All fees with exception of SDI releases shall be collected prior to release.**

Signature, Patient or Legal Representative_____
(*Minors 12 years or older must sign as patient along with the guardian*)_____
Relationship to Patient *(if signed by Legal Representative)*_____

Date_____ **Time** _____**am/pm** ☐ **Copy of Identification Attached of *Person picking up records***

☐ **RECORDS PICKED UP BY:** ☐ Patient ☐ Authorized Agent, ***relationship to patient***_____
Print Name _____ Signature _____
Date: _____ Time: _____am/pm Name of Staff: _____

☐ **RECORDS FAXED/SENT: (OFFICE USE ONLY)**

By: Print Name _____

Date:_____ Time: _____am/pm

rev.10/22/14