REQUEST OF HEALTH CARE INFORMATION
PATIENT AUTHORIZATION

HERA Health Care
Dr. Mirela Cernaianu
910 Hampshire Rd, Suite A
Westlake Village, Ca, 91361
Ph# 805-379-9110 Fax# 888-972-9656

I hereby authorize and request you to release to:
To:____
Address:____
Phone #:_________________________ Fax #:______________________________

The request health care information may include information related to testing, diagnosis, and treatment for (check all that apply):

___ HIV (AIDS Virus)
___ Psychiatric disorders/ mental health
___ Sexually transmitted infections
___ Drug and/ or alcohol use

All records in your possession concerning ____
____

During the period from _________________ to ____________________________

<u>My Rights</u>

- I may revoke this authorization in writing. If I did, it would not affect any actions already taken by HERA Health Care based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. A way to revoke this authorization is to write a letter to the practice.

Once health care information is disclosed, the person or organization that received it may re-disclose it. Privacy laws may no longer protect it. I understand that I have a right to receive a copy
of this authorization upon request.

I understand the requested information is accessible in my portal, but I prefer to pay HERA Health Care the processing fees as stated in their medical records policy

Name:_______________________________________ DOB:__________________________
Signature:____
Address:____
Request Date:____________________________ Phone #:___________________________