AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

INDIVIDUAL AUTHORIZING DISCLOSURE:

DATE OF BIRTH: SOCIAL SECURITY NUMBER:

PERSON(S) OR ENTITY AUTHORIZED TO DISCLOSE INFORMATION/RECORDS:

Any records custodian, physician, nurse, pharmacist, or other person on behalf of:

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

Any and all health information and records in your possession, custody, or control regarding the above-named person including, but not limited to: Intake and patient information forms, background or medical history, consultations, medical records and/or charts, hospital records and/or charts, detailed and/or summary reports, digital or written notes by providers or their agents, digital or written impressions or opinions by providers or their agents, imaging or other studies, x-ray films, radiology films, monitoring strips, pathology slides, tissue sample reports, biopsy results, videotape or other image recording medias, prescriptions and pharmacy records, medication lists, correspondence, statements of charges, billing information, and consultation reports from other health care providers.

I give permission for any health care provider identified above to discuss my healthcare information including medical care and treatment and psychological condition(s) and/or psychiatric care and treatment, if any, as well as any of the above-described records with the person(s) or entities identified here below.

PERSON(S) OR ENTITIES BEING AUTHORIZED TO RECEIVE THE DISCLOSURE:

Attorneys, employees, or agents of the following firms, who should be contacted to arrange for production of digital files, if available:

Law Office of Amanda L. Thompson
1660 Hotel Circle North, Ste. 302, San Diego, CA 92108
T: 619-379-5447 • F: 619-369-5725
amanda@amandathompsonlaw.com

WAIVER OF PRIVILEGE:

I understand that information disclosed pursuant to this Authorization for Release may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA. I hereby waive any privileges between doctor-patient, psychologist-patient, psychiatrist-patient and any other privileges that exist or apply and this waiver is for the limited purpose of providing the above-described records and information to the person(s) or entities authorized by this release, whether by production of documents and files or discussion with the identified person(s) or entities.

EXPIRATION AND RIGHT TO REVOKE:

This Authorization for Release shall remain in effect for two years from the date signed, unless otherwise indicated below, or until the above attorney(s) no longer represent me, whichever occurs first. The individual authorizing disclosure has the right to revoke this Release at any time. Revocation must be done in writing and presented to each provider who has received this Release. Revocation cannot apply to information that has already been released in response to this Authorization but applies going forward to prevent future releases of information or records.

COPIES SAME AS ORIGINAL:
Copies of this signed Authorization for Release shall have the same force and effect as an original.

HIPAA RULE OF PRIVACY & COMPLIANCE WITH HIPAA:
The U.S. Department of Health and Human Services ("HHS") issued the privacy rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). A major goal of the privacy rule was to assure that an individual's health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being. This Release complies with HIPAA Privacy Rule as outlined at 45 C.F.R. §164.508(c).

Executed on _______________

____
Signature of Patient or Patient's Authorized Agent
Print Name: