Account Number:_____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT IDENTIFYING INFORMATION:

Patient's Name_____ Date of Birth:_____

Previous Names:_____ Social Security#_____

Address:_____

AUTHORIZES:

Name of health care provider/plan/other: _____

Address:_____

Phone:_____ Fax:_____

TO DISCLOSE TO: **Bradley H. Chesler MD**
12463 Rancho Bernardo #356
San Diego, Ca. 92128
Phone: (858) 673-9991

DATES OF INFORMATION TO BE DISCLOSED:

From:_____ TO:_____
Month/Date Month/Date

INFORMATION TO BE DISCLOSED:

☐ **Medical Records:** Any and all health information other than psychotherapy notes may be released including but not limited to mental health records protected by the Lanterman-Petris-Short-Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:_____

_____

☐ **All Psychotherapy notes may be released, except as listed:**_____

_____

☐ **Billing Records**

☐ **Specific Records/Information as follows:**_____

Account Number:_____

PATIENT'S NAME:_____

PURPOSE: (Check all that apply- copy fees may apply)
□ Further Medical Care □ Legal Investigation/Action □ Insurance Eligibility
□ Disability Benefits □Personal (At my request) □ Other_____

EFFECT OF REFUSAL TO SIGN
I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

EXPIRATION: This authorization is good until date/event:_____.
NOTE: If this item is left blank the authorization will expire one year from the date signed.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I understand that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may revoke this authorization at any time by notifying this medical practice in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization: or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining health insurance coverage. I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. I understand that I have a right to receive a copy of this authorization.

Patient Signature: _____ Date: _____

Print Name: _____

Legal Representative Signature:_____ Date:_____

Print Name:_____

If signed by a person other than the patient, complete the following:
1) Patient is: □ a minor □ legally incompetent or incapacitated □ deceased
2) Legal Authority: □ parent* □ legal guardian □ next of kin/executor of deceased
□ activated power of attorney for health care
*By signing above, I hereby declare that I have not been denied physical placement of this child.