HIPAA MEDICAL RECORDS RELEASE
FROM
PAVILION FAMILY PHYSICIANS

Authorization for use and/or disclosure of personal health information about you.

Patient Name: _____
Last First MI Maiden or Other Name

Date of Birth: ____-_____-_____ Phone: _____

Please **SEND** Medical information **TO:**

NAME: _____

ADDRESS: _____ CITY: _____STATE: _____ZIP: _____

PHONE: _____ FAX: _____

Date(s) of Service_____

Records: ☐ All Medical Records ☐ Billing/Claims Records ☐ Diagnostic Records (lab, x-ray, etc.)

☐ Other: _____

To include: ☐ HIV/STD _____ (initial) ☐ Mental Health _____ (initial)

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions, per your request, and no longer protected by these regulations.

You may **revoke this authorization** in writing at any time by sending written notification to:

Pavilion Family Physicians Phone: (714) 547-5404 Fax: (714) 547-0935
1140 W. La Veta Ave., Suite 700
Orange, CA 92868

Please note: Revocations do not apply to information that has already been disclosed or used before revocation has been received.

You have the right to receive a copy of this authorization.

This authorization is valid (MUST CHOOSE ONE):

□-Indefinitely □-1year □-Other: _____

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____
RELATIONSHIP TO PATIENT