HIPAA MEDICAL RECORDS RELEASE
TO
PAVILION FAMILY PHYSICIANS

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

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

Patient Name: ____

Last First MI Maiden or Other Name

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

Please **REQUEST** Medical Information **FROM:**

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:

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