HIPAA RECORDS RELEASE

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: ______________________

Date(s) of Service____

Please select **Option 1** if you are requesting records **FROM: Pavilion Family Physicians** or **Option 2** for records going **TO: Pavilion Family Physicians**.

1. ☐ **I hereby authorize Pavilion Family Physicians** to disclose the following records to individual listed below **(MUST BE FILLED OUT COMPLETELY),** related to the date(s) above:

NAME:____

ADDRESS:______________________________ CITY:____________________STATE:_________ZIP:_________

PHONE:______________________________ FAX:______________________________

2. ☐ **I hereby authorize the individual listed below (MUST BE FILLED OUT COMPLETELY):** to disclose the following records to Pavilion Family Physicians, related to the date(s) above:

NAME:____

ADDRESS:______________________________ CITY:____________________STATE:_________ZIP:_________

PHONE:______________________________ FAX:______________________________

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This authorization remains in effect until it is withdrawn in writing.

______________________________ __________ OR ______________________________ __________
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

____
RELATIONSHIP TO PATIENT