CENTER FOR INTEGRATED CARE

15340 Devonshire St. Unit 7 Mission Hills, CA 91345

(323) 879-9176 Office

(818) 484-4084 Fax

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_ Zip: \_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request that my protected health information (PHI) from Center For Integrated Care be disclosed to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_

Zip-code:\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the following PHI to be released from my medical record(s):

 Entire Record  Treatment Progress  Diagnosis  Test Results  Dates of Treatment  Treatment Plan or

Goals  Prognosis  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Covering the period of healthcare from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose for disclosure of information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this authorization form, I understand that:

• Requests for copies of medical records are subject to reproduction fees as authorized by state/federal law. I agree to pay for any requested services that may not be covered by my insurance. Fee Charge $\_\_\_\_\_\_\_\_\_\_\_.

• I have the right to REVOKE this authorization at any time. Revocation must be made in writing and presented or mailed to treatment facility. Revocation will not apply to information that has already been disclosed in response to this authorization.

• This authorization will expire at the end of treatment.

• Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.

• Any disclosure of information carries with it the potential for unauthorized redisclosure.

• I have the right to receive a copy of this signed authorization. A copy or fax of this authorization is as valid as the original.

Signature of Patient or Authorized Representative Relationship to

Patient (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_