**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Name), authorize Dr. Diane Danis, M.D., M.P.H. to disclose health information for Myself or my Child

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name).

**Information to be Disclosed:** I authorize the release of the following health information:

\_\_\_\_\_\_All information relating to my/my child’s medical history, mental or physical condition and treatment.

\_\_\_\_\_Only the following records or types of health information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Recipient of Information:** I would like the information authorized above to be sent electronically to the following health care provider/s. I understand that, if the recipient is unable to accept medical records sent electronically, the records will be sent electronically directly to me.

 **Provider name & Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Provider name & Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Term:** I understand that this Authorization will remain **in effect for one year** from the date of this Authorization.

**Redisclosure:** I understand that Dr.Danis cannot guarantee that the recipient will not redisclose my/my child’s health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information**.**

**Electronic Transmission of medical information:** I understand that Dr. Danis will send medical records electronically. All medical records are sent via a secure HIPAA compliant server. Once this authorization is received, if you will be receiving the records, you will be sent an e-mail explaining how the system works.

**Right to Revoke:** I understand that I can revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. The revocation will be effective immediately upon the health care provider’s receipt of written notice. The revocation will not have any effect on any action taken by my health care provider in compliance with this Authorization before receiving the written notice of revocation.

Dr.Danis may be contacted in writing for answers to any questions about the release of health information at the following address: Post Office Box 94080, Pasadena, CA 91109.

**I have read the above Authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this Authorization.**

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_

Name of Guardian/Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_