Howard Medical Corp

101 West Avenida Vista Hermosa, Suite 122
San Clemente, CA 92672
Phone: (949) 212-2699 Fax: (888) 999-8503
www.HowardMedicalCorp.com

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Email: _____

Check ONLY one of the following two options:

__ I am requesting that _____ _____ _____ ___ _____

Release information I have indicated below to:
Howard Medical Corp:
101 West Avenida Vista Hermosa, Suite 122
San Clemente, CA 92672
Phone: (949) 212-2699 Fax: (888) 999-8503

__ I am requesting that Howard Medical Corp, 101 West Avenida Vista Hermosa, Suite 122, San Clemente, CA 92672

Release information I have indicated below to: _____, _____
_____, ___ _____ Phone: _____ Fax: _____

Check **ONLY one** of the following two selections to identify the health information to be released.

__ Selection 1: All patient health records from all dates of service

__ Selection 2: Records as specified. You must complete Step 1 and Step 2 below.

Step 1. Enter date range or date(s) of the records to be released: _____ to _____

Step 2. Select types of records to be released: By **checking** the spaces below, I specifically authorize the use and/or disclosure of the following medical information and/or medical records, if such information and/or records exist:

__ Mental health information and/or records __ Progress notes __ Laboratory reports

__ Patient Demographics __ Lab reports __ Emergency and urgent care records

__ Clinic Records __ Billing statements

__ Psychotherapy notes __ Genetic testing information and/or records

__ *Drug/alcohol diagnosis, treatment or referral information __ *Other sexually transmitted diseases __ *HIV-Positive test results and HIV diagnosis

(Federal regulations require a description of how much and what kind of information is to be disclosed.)

Describe: _____

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

This Authorization will expire one year from date signed unless otherwise noted here: _____

Print patient's Name or name of patient's legal representative: _____

_____ _____
Signature of Patient Date of Signing

_____ _____
Signature of Patient's Representative Date of Signing

_____ _____
Relationship of Representative to Patient Name of Interpreter / ID #