**TARZANA ENDOCRINE AND MEDICAL GROUP**
**18370 BURBANK BLVD., #601,** **TELEPHONE: (818) 996-5700**
**TARZANA, CALIFORNIA 91356** **FAX: (818) 996-1649**

# Authorization For Release of Health Information

***As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.***

TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS WILL NOT BE CONDITIONED ON MY PROVIDING OR REFUSING TO PROVIDE THIS AUTHORIZATION.

PLEASE REQUEST MEDICAL INFORMATION FROM: PLEASE SEND MEDICAL INFORMATION TO:

_____. [PHYSICIAN] _____.

_____. 18370 BURBANK BLVD., SUITE #601,

_____. TARZANA, CALIFORNIA 91356

I hereby authorize this above medical practice to use and disclose health information concerning

_____

(P*atient name and address*) as follows:

_____Telephone Number_____Date of Birth.

**Health information to be used or disclosed (check *only one box*): ***

☐ Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:

_____

All psychotherapy notes may be released, except as specifically provided below:

_____

General Medical Information From: _____to_____.

Includes x-ray reports, laboratory results and all medical care.

**The information may be used only for the following purposes (if you do not want to explain the purpose, write "At the request of the individual ---"**

_____

_____

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

DURATION: THIS AUTHORIZATION SHALL BECOME EFFECTIVE IMMEDIATELY & SHALL REMAIN IN EFFECT FOR ONE YEAR FROM DATE OF SIGNATURE, UNLESS SPECIFIED OTHERWISE.

**Effect of Refusal to Sign Authorization [Note: Physician Practice must include one of the following, as appropriate:]**

[I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.] ***or***

[I understand that if I do not sign this form:]

[I cannot participate in this research-related treatment.]

[A health plan may not enroll me or make me eligible for benefits.]

[My physician will not perform the expert, employment, life insurance or other physical or medical evaluation which would otherwise be performed solely for the purpose of disclosure to a third party.]

This authorization is effective now and will remain in effect until _____
(*Expiration event or date*).

I understand that I have the right to receive a copy of this authorization.
*A COPY OF THIS AUTHORIZATION IS VALID AS AN ORIGINAL.*

Signed: _____ Dated: _____

Print Name: _____

If not signed by the patient, please indicate:

Relationship:

- ☐ parent or guardian of minor patient (to the extent minor could not have consented to the care)
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient ******
- ☐ spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)

Name of patient: _____

*****Signed: _____ Dated: _____
*Treating Physician*