# HIPAA AUTHORIZATION FORM
## FOR RELEASE OF PROTECTED HEALTH INFORMATION

**Patient Name:** _____

**Patient Name at Time of Treatment** *(if different than above):*
_____

**Address:** _____
_____
_____

**Date of Birth:** _____
**Social Security #:** _____
**Phone Number:** _____
**Email:** _____

**Date(s) of Service for requested information:**
_____

**I hereby authorize (name and address of hospital/doctor's office that created the medical records):**
Neufeld Medical Group/Dr Naomi Neufeld
8733 Beverly Blvd Suite 201
Los Angeles, CA 90048

**To release my medical records to (complete name, address and contact information):**
_____
_____
_____Physician Fax:_____

**Please release the following information in my medical record (check all that apply):**

- ▫ History & Physical
- ▫ Consultation Report(s)
- ▫ Discharge Summary
- ▫ Operative Report(s)
- ▫ Emergency Room Record
- ▫ Laboratory Report(s)
- ▫ X-Ray/Imaging Report(s)
- ▫ X-Ray/Imaging FILMS
- ▫ Entire Medical Record
- ▫ Abstract or Summary:
- ▫ Other: _____

**Please release the following information in my medical record (check all that apply):**

I ▫ do ▫ do not want HIV/AIDS information released under this authorization.

I ▫ do ▫ do not want mental health information released under this authorization.

I ▫ do ▫ do not want drug/alcohol abuse or treatment information released under this authorization.

I ▫ do ▫ do not want genetic testing information released under this authorization.

I ▫ do ▫ do not want sexually transmitted disease information released under this authorization.

**The purpose for release of the above information is for:**

▫ Continuation of Care ▫ Insurance ▫ Legal ▫ At my request (patient only) ▫ Other: _____

This authorization will expire within one (1) year unless otherwise indicated. I understand that this authorization is voluntary and may be revoked by me at any time in writing except to the extent that action has already been taken in reliance with this authorization.
I understand that my hospital/doctor's office may or may not condition my treatment, payment, enrollment in a health plan or eligibility for benefits upon my authorization of this disclosure. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act.

**PLEASE PROVIDE A COPY OF PHOTO IDENTIFICATION WITH THIS RELEASE FORM**

_____
**Signature of Patient or Patient's representative**
(Personal & Legal Representative must include proof of status)

- ▫ Parent
- ▫ Personal Representative
- ▫ Legal Representative

_____
**Date**

_____
**Witness**

**FORM MUST BE COMPLETED IN ITS ENTIRETY OR IT WILL BE RETURNED:**
**Iron Mountain ROI, 3900 Nome St Unit J, Denver CO 80239**