Ventura Orthopedics

DataFile Technologies

Outgoing Records
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient: ______________________

Date of Birth: ______________ SSN: ______________

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization. I understand that I have a right to receive a copy of this Authorization.

Requesting records from:

Ventura Orthopedics
Phone: (800) 698-1280
Fax: (805) 527-5246

Where to send the records to:
Name/Facility: ______________________
Attention: ______________________
Address: ______________________
City: ______________ State: ______ Zip: ______
Phone: ______________ FAX: ______________
Check box if you prefer a CD

Please send records from the following date range: From: ______________ To: ______________

Labs
History and Physical
Consultation Notes
Progress Notes
X-rays/Film
Billing Records
Other

Purpose of requested use:
Continuing Care
Patient Request
Insurance
Legal
Other

I authorize release of the following information:
Mental health treatment information — Initial if requesting: ______________
HIV test results — Initial if requesting: ______________
Alcohol/drug treatment information — Initial if requesting: ______________

**If not checked and initialed, the records containing such information can NOT be released.*

Duration: Date authorization expires: ______________________
**If no date is given, this authorization will expire 6 months from the signature date.*

Revocation: I may revoke this authorization at any time, but I must do so in writing and submit it to Ventura Orthopedics. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

Redisclosure: Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

Conditioning: I may refuse to sign this authorization. If I refuse to sign this authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Patient Signature: ______________________ Date: ______________

Representative Signature: ______________________ Relationship to Patient: ______________