

**Outgoing Records
AUTHORIZATION FOR USE OR
DISCLOSURE OF HEALTH
INFORMATION**

Patient: _____

DOB: _____ 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: _____

- | | | |
|---|---|---|
| <input type="checkbox"/> Labs | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Consultation Notes |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> X-rays/Film | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> Other | | |

Purpose of requested use:

Insurance

Continuing Care

Legal

Patient Request

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: _____