Ventura Orthopedics

verisma | ScanSTAT TECHNOLOGIES

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 requeste d may invalidate this Authorization.
I understand that I have a right to receive a copy of this Authorization.

Requesting r ecords from:

Ventura Orthopedics
Phone: (800) 698 -1280
Fax: (805) 5 27 -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: F rom: _____ T o: _____

☐ Labs ☐ History and Physical ☐ Consultation Notes
☐ Progress Notes ☐!X- rays/ Film ☐ Billing Reco rds
☐ 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 author iz ation 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 i n reliance upon this a uthorization.

Re disclosure: Information disclosed pursuant to this authorization could be re disclosed by the recipient. Such re disclosure is in some cases not protected by Calif ornia law and may no longer be protected by federal confidentiality law (HIPAA).

Conditioning: I may refuse to sign this a uthoriza tion. If I refuse to sign this a uthorization, 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: _____