Ventura Orthopedics

verisma | ScanSTAT TECHNOLOGIES

Patient: _____

E-mail: _____

DOB: _____ SSN: _____

Outgoing Records Authorization For Use or Disclosure of Health Information

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

Send the records to: ☐ Check box if you prefer a CD

Name of facility: _____

Attention: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

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

☐ Labs ☐ History & Physical ☐ Consultation Notes ☐ Progress Notes ☐ Billing Records

☐ X-Rays / Film ☐ X-Ray Reports ☐ MRI/CT ☐ 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: _____