**Southern California Heart Specialists**
Comprehensive care for the heart…from the heart
Office (626)294-4888
Fax (626)294-4880 Account # _____
301 W Huntington Dr Suite 500 Arcadia, CA 91007

# HIPAA Privacy Authorization Form

As required for Use or Disclosure of Protected Health Information by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164 and the state of California, our practice may not use or disclose your identifiable health information except as provided by our Notice of Privacy practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure as described below.
I hereby authorize this medical practice to use and disclose my health information.

I, _____, authorize to use and disclose my protected health information for the purpose of reviewing my records:

**From:** MD/Office Name: Southern California Heart Specialists

**To:** MD/Office Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____ Fax:

Information to be released and the **Effective Period of the Protected Health Information**

- ☐ All medical records
- ☐ All medical billing records
- ☐ Imaging and or Test Reports
- ☐ Other records
- ☐ Record Dates:_____

1. I understand that my "express consent" is required to release any healthcare information relating to testing, diagnosis and or treatment for HIV, sexually transmitted diseases, mental illness disorders, mental health or drug abuse and or alcohol abuse. If I have been tested, diagnosed or treated for HIV, sexually transmitted diseases, mental illness disorders, mental health or drug abuse and or alcohol abuse you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.
2. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, diagnosis and treatments performed and or ordered by the specific party I authorize in this release.
3. I understand that although federal law does not protect health information which is disclosed to someone other than a health care provider, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically permitted by law.
4. I further understand that federal law restricts re-disclosure of alcohol/chemical dependency diagnosis, treatment or referral data and specifically requires *my authorization prior to re-disclosure*.
5. I understand I may revoke this authorization in writing at any time. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Any use or disclosure already made with my permission cannot be undone.
6. I understand my health care treatment or benefits will not be affected whether I sign or do not sign this form and that I have a right to receive a copy of this authorization.

This authorization will expire 90 days from the date signed. A copy or facsimile of this authorization shall be counted true and valid as original.

Patient Name: _____

Address: _____

City/State/Zip: _____

Telephone number: _____ Date of Birth_____

Patient Signature: _____ date: _____