



P.O. Box 991522
Redding, CA 96099-1522
(530) 241-2971
Fax: (530) 241-6928
roi@ProMedCopy.com

Authorization to Release Protected Health Information

Completion of the document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

Patients Name
Please Print Full Name
Phone
Email
Other Names Used
Date of Birth
Social Security Number (Last 4 Numbers Only)
Current Address
Street, City, State, Zip Code

I hereby authorize and/or their agents, Professional Medical Copy to review, make copies of and release my medical information to:

Persons/Organizations authorized to receive information
Persons/Organizations Street, City, State, Zip Code

Information to be Released

The type of information to be released includes the following (please check applicable boxes):

- Last 6 months of treatment (beginning from last visit)
Last year of treatment (beginning from last visit)
Entire Record (including Paper & Electronic Records)
Other
List and Specific Dates

I hereby consent to the release of all alcohol and/or drug abuse information relating to sexually transmitted disease, acquired Immunodeficiency Syndrome (AIDS), human Immunodeficiency Virus (HIV), or psychiatric treatment records under the same conditions outlined above.

I understand that such information cannot be released without my specific consent.

Signed Date

Notice of Rights and Other Information

- I understand the authorizing release of this information is voluntary. If I refuse to sign this authorization, the requested information will not be released.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me (or a legal representative), and delivered to the health information management department.
- I understand that the revocation will not apply to information that has already been released in response to this authorization.
- Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that if I fail to specify an expiration date, event or condition, this authorization will expire in one year from date of execution.
- I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.
- I will be given a copy of this authorization form if I request it.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by the federal law. However, California law prohibits the person receiving health information from further release without authorization unless required or permitted by law.

Signed _____ **Date** _____

I am aware that Professional Medical Copy is a confidential correspondence copy service contracted by the physician and/or facility, and through their service my records request will be processed and delivered as instructed. Professional Medical Copy abides by the guidelines of Health Insurance Portability and Accountability Act (HIPAA) and the protection of Protected Health Information (PHI), records are invoiced pursuant to 45 CFR 164.524 - Access of Individuals to Protected Health Information.

- I understand that all costs for requests will be invoiced at a cost base rate.
- I understand that Professional Medical Copy will invoice me for this service and agree to pay for their services.
- I understand by signing below I acknowledge the above charges and my acceptance of the personal financial responsibility.
- I understand that expanded dates or additional request for other providers will be subject to additional charges.
- I understand that invoices not paid within 30 days are subject to a \$15^o Late Payment Fee and Finance Charges at the rate of 18% APR.

Signed _____ **Date** _____