AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

In order to be valid, this form must be completed in full including signature(s) and dates(s) wherever applicable.

Patient's Full Name_____Date of Birth___/___/____
Address_____City_____State____Zip_____
Primary Phone (____)_____-_____ Secondary Phone (____)_____-_____

I authorize: **Tiffany M. Becker, M.D., 827 Deep Valley Drive Ste. #201, Rolling Hills Estates, CA 90274**
Phone: (310) 541-5400 Fax: (310) 541-5466

Select one and complete right: Clinic/Provider/Other Name:_____
☐To Forward records to: Address:_____
☐To receive records from: City:_____ State_____ Zip:_____
☐To verbally exchange with: Phone: (____)_____ Fax: (____)_____

Purpose of release (check only one): ☐ Change healthcare provider ☐ Consultation ☐ Legal
☐ Other_____

By **initialing** in the spaces below, I specifically authorize the release of that specific medical information:

___ Clinician office chart notes ____ Immunization History ____Hospital Records
___ Diagnostic Imaging Reports (X-rays…) ____ Laboratory reports ____ Other_____

If the information to be disclosed contains any types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

____ HIV/AIDS ____Mental Health/ADD/ADHD diagnosis, treatment or referral
____ Genetic testing information ____ Drug/Alcohol diagnosis, treatment or referral information

The medical information authorized above (check only one) ☐ **MAY** or ☐ **MAY NOT** be faxed. I understand there is a risk in faxing records and confidentiality cannot be guaranteed.

My signature below indicates that I understand and agree to the following:

- I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.
- I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before the provider received my written notice of revocation.
- I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have the right to receive a copy of this authorization from my health care provider.
- A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.
- That proof of guardianship or a court order may be required if signing for a person under 18 years of age.

_____ _____ _____
SIGNATURE of Patient or Legal Representative **RELATION** to Patient Date

_____
PRINTED NAME of Patient or Legal Representative