

AUTHORIZATION FOR THE RELEASE OF RECORDS

DATE: _____

You are hereby authorized to deliver, disclose, and release any and all information concerning medical care rendered to me, including, but not limited to, diagnoses, x-rays, x-ray interpretation, thermograms, laboratory and pathological tests, medical history obtained, medical reports of medical examinations (both inpatient and outpatient), medical chart notes, therapy and other notes, pre-operative reports, physical rehabilitation reports, chiropractic reports, and billings or charges for all or part of said services. This release shall extend to the release of mental health records including records relating to psychological treatment, psychiatric treatment, and/or drug abuse treatment subject to the Lanterman-Petris-Short Act, and/or Federal Alcohol and Drug Abuse Regulations. This release shall extend to the release of any and all information in relation to the diagnosis and/or treatment of HIV (AIDS) virus; all sexually transmitted diseases. These records are being released for the purpose of handling my insurance claim in compliance with the appropriate governing codes including California Civil Code Section 56 et seq., California Evidence Code Section 1158. et. al.

This authorization shall remain valid until such time as my claim is settled and closed.

I understand that I have a right to receive a copy of this authorization.

NAME: _____

OTHER NAMES USED: _____

SOCIAL SECURITY #: _____/_____/_____ BIRTH DATE: _____

DRIVER'S LICENSE (OR ID) #: _____ STATE: _____

Private Health Insurance Provider: Name _____ Group# _____

A photocopy of this AUTHORIZATION shall be deemed as an original.

Signature

Date signed

RELEASE RECORDS TO AUTHORIZED REPRESENTATIVES OR MAIL TO:

ATTN: _____ Claim# _____