California Center for REPRODUCTIVE MEDICINE

Authorization for Use or Disclosure of Health Information

EXPLANATION: This form authorizes Lori Arnold, M.D. to obtain or disclose your protected health information in the manner indicated below and is voluntary. Lori Arnold, M.D. cannot obtain nor release information without your signature except under limited circumstances described in Lori Arnold, M.D. Notice of Privacy Practices. Please be aware that once your *Protected Health Information* is released to other entities Lori Arnold, M.D. will no longer be able to protect that information and the recipients of your information may not be legally required to protect your information.

1. AUTHORIZATION: I hereby authorize *Lori Arnold, M.D.* to:

2. ☐ **FURNISH TO** [or] ☐ **OBTAIN FROM**_____

Address, City, State & Zip: _____

Phone: _____ Fax: _____

health records and information pertaining to medical history, mental or physical condition, services rendered, or the treatment of:

3. Patient's name:_____ Social Security_____ Date of Birth_____

Services from _____, _____ to _____, _____ ☐ Physician office ☐ Inpatient ☐ Outpatient ☐ Emergency

4. I understand that this may include information relating to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, Psychiatric care, and/or treatment for alcohol and/or drug abuse.

5. TYPE OF INFORMATION: This authorization is limited to the following medical records and type of information*:*

☐ History/Physical Examination ☐ Progress Notes ☐ Laboratory Tests ☐ X-Ray / Ultra Sound Reports ☐ Consultation Reports

☐ Hospital / Surgical Reports including H & P and discharge summary. ☐ Images, such as photographs or videotapes. ☐ Other_____

6. USES: The requestor may use the medical records and type of information authorized only for the following purposes:

☐ Continuing Care ☐ Personal Copy ☐ Second Opinion ☐ Legal Matter ☐ Insurance Claim

☐ Records Inspection ☐ Specify Other _____

7. DURATION: I understand that this authorization may be revoked in writing at any time, according to the instructions in the Lori Arnold, M.D. Notice of Privacy Practices, except to the extent that action has been taken in reliance of this authorization. Unless otherwise revoked, this authorization will expire six months from the date of this authorization.

8. RESTRICTIONS: I understand that Health Information that Lori Arnold, M.D. obtains may not be further used or disclosed unless another authorization is obtained from me.

9. Additional Copy: I understand that I have a right to receive a copy of this authorization upon my request (Civil code s.56.11)
A charge of $25.00 per patient chart is due at time of release of records. For large files (more than 50 pages) and additional fee of $15.00 will be charged.

10. LIABILITY RELEASE: My signature below releases both Lori Arnold, M.D. and the party listed in #2 from any/all legal liability that may arise from the obtaining or release of my protected health information.

11. Signature:_____ Date_____

12. Printed Name_____ relationship _____ If signed by other than patient

13. Witness:_____

14. ***Protected Health Information is strictly confidential and is for the information of the individual or entity indicated above. Lori Arnold, M.D.*** *will accept no responsibility if it is made available to any other person, including the patient. For certain patient records, state and federal laws protect confidentiality. These laws prohibit you from making any further disclosure without the specific written authorization of the person to whom the information pertains or as otherwise permitted by regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.*

15. ***Information in this form is privileged and confidential and is intended only for the recipient(s) listed above.*** *If you are neither the intended recipient nor responsible for the delivery of this transmittal to the intended recipients(s), you are hereby notified that any unauthorized distribution or copying of this transmittal is prohibited. If you have received this transmittal in error, please notify us immediately at 760.633.2231..*

MedRec5/03