Inland Pain Specialists

PATIENT LABEL

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Are you the Patient?

☐ Yes ☐ No, I'm the patient's legal/personal representative*

**Note:* *If you're not the patient, you may be asked to provide supporting documentation to verify that you are authorized to make this request on behalf of the patient.*

Patient Information

Patient Name:		Date of Birth:	
Address, City, State, ZIP:			
Patient Phone:		Email:	

Who do you want to request records from?

Healthcare Provider or Facility Name:			
Address, City, State, ZIP:			
Phone:		Fax:	

Where do you want the records sent to? *Note: We can release information only to who you authorize.*

☐ **Check this box if records are being sent to the patient only. No further action in this section needed.**

Recipient Name:			
Recipient Address, City, State, ZIP:			
Recipient Phone:		Recipient Fax or Email:	

What is the reason for requesting records?

☐ I'm moving and/or switching doctors ☐ Getting a second opinion ☐ Seeing a Specialist
☐ Military Enlistment ☐ Personal Use ☐ Other reason: ______________________________

What treatment dates of service are you looking for?

Specify an approximate* date range – Start: _____/_____/_____ to End: _____/_____/_____

**Date range doesn't have to be exact. Enter dates to the best of your ability.*

What types of records would you like? *Note: Some records may only be available on paper or PDF.*

☐ Clinic/Doctor's Office Visit Notes – ALL Providers ***OR*** ☐ Following Specific Provider(s) ONLY:

____

☐ Hospital Records ☐ Immunizations ☐ Lab Test Results ☐ Radiology Reports (CT, MRI, X-ray, etc.)
☐ Operative Reports/Procedure Notes ☐ Physical/Occupational/Speech Therapy Records
☐ Other (Please specify)

Please describe the specific records you're requesting to help us respond more completely to your request. (Example: related to a condition or surgery, specific lab tests, all available records, etc.)

Do we have permission to release the following protected information* that may be contained in your records? Please check all that apply below. *Additional authorization may be required.*

☐ HIV Test Results ☐ Substance Use/Drug Abuse Records
☐ Mental Health Records ☐ Genetic Testing Results

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Is there a deadline for this request?

By law we have up to 15 days to fulfill your request. However, if you have an urgent need for an upcoming appointment, please let us know. We will do our best to honor your deadline.

☐ Yes, I have a deadline. Date needed: ______________________ ☐ No, just as soon as possible.

How would you like us to release the records? **Must select one (1) option ONLY*

☐ Patient Portal (My Health Online) ☐ Email (encrypted) ☐ Email (unencrypted)*

☐ Fax (50-page limit) ☐ CD (encrypted) by Mail ☐ CD (encrypted) by In-Person Pickup

Per Page Fees May Apply: ☐ Paper by Mail ☐ Paper by In-Person Pickup

For Additional Fee: ☐ USB flash drive (encrypted) by Mail ☐ USB flash drive (encrypted) by In-Person Pickup

**Sending information by unencrypted email increases the risk of being read by an unauthorized third party.*

Expiration Date

This authorization shall become effective immediately and remain in effect for one (1) year from the date signed below unless specified here*: ______________________________

**Optional Expiration Date (must be at least 15 days in the future from Today's date to be valid)*

Your Rights Under the Law

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and mailed to this address:
  - Inland Pain Specialists - 1307 West 6th Street Suite 105, Corona, CA 92882
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have the right to receive a copy of this authorization.
- I may inspect and obtain copy of my health information for which I am authorizing the use or disclosure for as long as the information is maintained by the affiliate(s) listed above.
- The location(s) listed above will not receive compensation for the use or disclosure of my health information.
- I understand that California law prohibits the recipients of my health information from making further disclosure of my health information unless the recipient obtains another authorization from me or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

SIGNATURE AND DATE *(As required by law)*

SIGNATURE: ________________________________ Date: ______________ Time: ______________

(Patient or Legal/Personal Representative*)

*If signed by someone other than the patient, print name and specify relationship to the patient:

Name: ______________________________________ Relationship: ____________________________