Gary N. Lewkovich, DC, QME, CO
Jason A. Edwards, DC
940 W. San Marcos Blvd. Ste, B
San Marcos, CA 92078
Office 760-744-1881 Fax 760-744-2103

Authorization to Release Protected Health Information (PHI)

Office Use Only
PHI: Mailed / Faxed / Picked-Up
ID Verified: Yes No
Date Request Received: _____
Date Request Processed: _____

To: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Patient: _____

Address: _____

Phone: _____ Email: _____ Date of birth: _____

Information to be Disclosed: This authorization permits the above provider to disclose the following medical records:

- ☐ All of the records in my file, from this or other healthcare providers.
- ☐ All of my healthcare records except the following: _____
- ☐ Only records from dates of service ___/___/___ to ___/___/___
- ☐ Only records related to (check all that apply):
  - ☐ History and Exam ☐ Treatment notes ☐ X-ray /Imaging studies ☐ Reports ☐ Billing information
- ☐ Records related to a specific incident or condition (specify): _____

Purpose of this Disclosure: I understand that the specific purpose of this authorization is for:

☐ Review by the provider listed below ☐ Insurance company review ☐ Attorney review ☐ Other: _____

Term of this Authorization: This authorization shall remain in effect:

- ☐ From the date of this authorization until ___/___/___
- ☐ Until the following occurs: _____
- ☐ Until the provider fulfills this authorization request.

(If not specified, this authorization expires in 60 days of signing.)

Redisclosure of this Protected Health Information Information to be Disclosed

I understand that once my healthcare provider discloses my Protected Health Information to another recipient identified in this form, my healthcare provider cannot guarantee the recipient will not disclose this information to a third party. The third party may not be required to abide by this authorization or the applicable federal/state laws governing the use and disclosure of this Protected Health Information.

Refusal to Sign this Form and Right to Revoke

I understand that I may refuse to sign this form or that I may revoke this authorization at any time, for any reason, and that such refusal or revocation will not affect my treatment by my healthcare provider. However, without your signature on this form, this office is unable to release your Protected Health Information, except as prescribed by law or regulation, and outlined in the Privacy Practices Notice.

Revocation

I understand that this authorization will remain in effect until the term of this authorization expires or at such time that I provide a written notice of revocation to this office. This revocation will remain in effect immediately upon this office's receipt of my written notice. I understand that this revocation will not have any effect on disclosures that relied upon this authorization and were made prior to the receipt of my written revocation.

Inspect and/or Copy

I understand that I have the right to inspect and/or copy the Protected Health Information to be used by the authorization.

Questions

If I have a question, I may contact this office with the above contact information.

This authorization does not extend to HIV testing/results, psychotherapy notes, or drug/alcohol records that are protected by state or federal law.

Authorization for Use/Disclosure of Protected Health Information

I am the patient, or legally authorized representative for the patient listed above. I voluntarily authorize and direct you to use or disclose information during the term of this authorization to the recipient identified below:

☐ Gary N. Lewkovich, DC, QME, CO ☐ Jason A. Edwards, DC ☐ Myself ☐ Another Person/ Office/Facility/Company

Recipient's name and contact information if he or she is NOT the above indicated healthcare provider (please PRINT):

Name: _____ Address: _____

Phone: _____ Fax: _____ Email Address: _____

Please Sign this Authorization Below

Patient's Signature: _____ Date: _____

or

Signature of authorized agent for the patient: _____ Date: _____

☐ Guardian/Representative ☐ Spouse of patient ☐ Legal representative ☐ Party acting as loco parentis ☐ Other: _____

LEGAL NOTICE

--By signing this form for someone else you are indicating that you have the legal authority to act on behalf of this patient. --