

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEDICAL INFORMATION:

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing to refusing to provide this authorization.

I hereby authorize _____ to release and/or disclose health/medical information to the entity indicated below.* (Location/Facility Name)

Release records & information regarding: _____

Name of Patient (List Other Names Used)

_____-_____-_____-

_____/_____/_____

Social Security Number

Date of Birth

Release Medical Information to:

Los Angeles Legal Service
2107-D West Commonwealth Ave., #380
Alhambra, CA 91803
(626) 289-0179 * Fax: (626) 289-7091



DURATION:

This authorization shall become effective immediately and shall remain in effect until ____/____/____ (Enter Date) or for one year from the date of signature if no date entered.

REVOCAION:

This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

REDISCLASURE:

I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

SPECIFY RECORDS: Check the box and initial what type of information is to be disclosed:

- MEDICAL INFORMATION BILLING INFORMATION PSYCHIATRIC INFO. DRUG/ALCOHOL/HIV

_____/_____/_____
Date of Incident / MR #

Date of Incident

Initials

Date

Initials

Date

OTHER (Specify): _____

Records being requested by: _____

Name of Client

Address

City, State, Zip Code

(____) _____ - _____, (____) _____ - _____

Telephone Number

Fax Number

A copy of this authorization is valid as an original. I have a right to receive & keep a copy of this authorization. (*I request that the health/medical information released and/or disclosed pursuant to this authorization to be used for the purpose of pending legal proceedings only.)

_____/_____/_____
Date

X _____
Signature of Patient or Patient's Representative

Indicate Relationship (If Signed by Other Than Patient)