EDINGER MEDICAL GROUP

Medical Records Release Form

Completion of this form authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization. Form fields with a red asterisk (*) are required.

Patient Information

Patient's Full Name *

First Name *Middle Name* *Last Name*

Patient's Date of Birth *

Month *Day* *Year*

Phone Number (optional)

Email Address (optional)

How Can We Help?

Please indicate how Edinger Medical Group can assist you with your medical records. If your request requires more than one of the options listed below, please complete a separate form.

I (the patient) authorize Edinger Medical Group to: *

- ◯ get my records from an outside physician's office
- ◯ send my records to an outside physician's office
- ◯ mail my records to my home address

Outside Physician's Information

(ONLY COMPLETE THIS IF YOU CHOSE "GET/SEND MY RECORDS FROM/TO AN OUTSIDE PHYSICIAN")

Name of Physician/Facility

Example: Dr. John Smith at Orange Coast Eye

Fax Number

Address

Street Address

Street Address Line 2

City

State

Postal / Zip Code

Patient's Home Address

(ONLY COMPLETE THIS IF YOU CHOSE "MAIL MY RECORDS TO MY HOME ADDRESS")

Address

Street Address

Street Address Line 2

City

State

Postal / Zip Code

Health Information Release Authorization

Date Range of Health Information *

INVALID if NOT filled in (Example: MM/DD/YYYY to MM/DD/YYYY)

Part A: Health Information to be Requested/Released *

- ☐ Billing Records
- ☐ Lab Reports
- ☐ Specific Visits
- ☐ X-Ray Reports
- ☐ Immunization Records
- ☐ OB/GYN Records
- ☐ X-Ray Films
- ☐ Other _____

Part B: In compliance with California Statutes, which require special permission to release otherwise privileged information, please INITIAL next to the records that you want released: (separate specific authorization required)

Mental Health	Drug Abuse	Alcohol Abuse	HIV/AIDS Testing

By initialing here, I (the patient) hereby authorize the use and/or disclosure of my health information as described in Parts A and B. *

Reason for Request

Reason for requesting medical records: *

- ◯ I am a new patient
- ◯ Sending to a Specialist
- ◯ Personal reasons
- ◯ Other _____
- ◯ I am leaving Edinger Medical Group
- ◯ Employment
- ◯ School/College

If you chose "I am leaving Edinger Medical Group", please share why: *

- ◯ Moving out of the area
- ◯ Dissatisfied with my care
- ◯ Insurance no longer accepted
- ◯ Other _____

Information Regarding the Release of Health Information

Edinger Medical Group recognizes the patient's right of confidentiality of their health information under federal privacy regulations and California law. The patient should be aware of the following information when requesting or releasing health information.

Right to Refuse to Sign this Authorization: This authorization is voluntary. Refusal to sign will not affect the patient's ability to receive treatment or payment of claims.

Right to Inspect or Receive a Copy of Health Information to be Used or Disclosed: A patient has the right to inspect or obtain a copy of the health information they have authorized to be used or disclosed by signing this Authorization form.

Right to Receive a Copy of this Authorization: A patient has the right to revoke his authorization at any time by giving written notice of revocation to the Privacy Officer. Revocation of this authorization WILL NOT affect any action taken in reliance of this authorization before receipt of the written notice of revocation.

Multiple Releases of Information: A patient may request multiple releases of the information stated on the Authorization form. However, all releases based on this form are limited to records dated up to and including the date of the patient's signature. A new authorization is necessary for release of information for care provided after the date of the patient's signature, UNLESS the authorization specifically states that SPECIFIC RECORDS that will be generated in the future may be released, for example, "future records of a specific test" or "future records of specific clinic appointment."

Who May Sign this Authorization

1. Generally, all patients 18 years of age and older must sign for release of their own health information unless the following conditions apply:
   - The patient is incompetent.
   - The patient is disabled and cannot sign the form.
   - The patient is deceased. (A surviving spouse or personal representative of the estate may sign. If there is no surviving spouse or representative, then an adult member of the immediate family may sign.)
   - IMPORTANT: With very few exceptions, if the patient is age 18 or older, parents' signatures ARE NOT acceptable.
2. All persons signing for release of health information on behalf of the patient must state their relationship to the patient and provide legal proof of legal authority of their capacity to act for the patient.
3. Minors: Patients less than 18 years of age must sign for release of health information in the following cases:
   - Alcohol or other drug-related abuse treatment: age 12 or older.
   - Mental health treatment: age 12 or older may consent to release of records without parental consent.
   - HIV test results: age 12 or older.
   - Emancipate minors who are married or in the military.

Fees for Records: Copies of a patient's medical record sent directly to another physician or medical facility will be made generally at no charge; however, if many requests are made, a copying fee may be applied as allowed by California law.

If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be disclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.

Acknowledgement

This authorization will expire on the date below. If I (the patient) do not indicate a date, this authorization will expire one (1) year from the date of my signature.

Month Day Year

Signature *

Today's Date *

Signer's Full Name *

First Name Last Name

Was this signed by someone other than the patient? *

- ◯ Yes
- ◯ No

If yes, please state your legal relationship to the patient.

Any Questions? Please contact us:

Edinger Medical Group - Medical Records
Email: medicalrecords@edingermedicalgroup.com
Fax: 714-965-2595
Phone: 714-965-2500, Option 6