AUTHORIZATION TO DISCLOSE HEALTH INFORMATION AND OTHER RECORDS
HIPAA COMPLIANT PURSUANT TO Section Code 164.508
(Page 1 of 2)

Patient Name: _____ Date of Birth: _____

Patient Address: _____ SS#: _____

Claim #: _____ Medical Record # (if applicable): _____

I HEREBY GRANT PERMISSION TO AND AUTHORIZE THE USE OR DISCLOSURE OF THE ABOVE NAMED INDIVIDUAL'S RECORDS AS DESCRIBED BELOW TO THE DESIGNATED ENTITIES:

And/or**ProDoc | Kytel**
875 Patriot Drive, Suite D
Moorpark, CA 93021

THE FOLLOWING INDIVIDUAL(S), MEDICAL PROVIDER(S), AND/OR ORGANIZATION(S) ARE AUTHORIZED TO MAKE THE DISCLOSURE:

Name	Address & Phone Number	Date Range of Treatment Requested

SPECIFY RECORDS: Check the box and initial below to specify which type of information to be disclosed

☐ MEDICAL INFORMATION (All Medical reports including but not limited to SOAPE notes, all other notes (typed or handwritten), records, charts, any letters, physical therapy records, lab reports and outpatient reports and discharge summary

☐ MEDICAL BILLING

☐ X-RAYS/FILMS (MRI's, CT-Scans, and Reports)

☐ Personnel, Attendance, Employment, Payroll, Wage Records from an Employer or School

☐ Insurance records, including all claims, itemized billing, correspondence, payments, and all documents within the file

☐ Drug/Alcohol Information _____ *(initial)*

☐ Psychiatric Information _____ *(initial)*

☐ Results of an HIV Blood Test _____ *(initial)*

☐ Other: _____

☐ Exclusions: _____

The above information is being obtained to assist said authorized entities in evaluation of my claim for benefits or damages. A copy or facsimile of this document shall be considered as effective and valid as the original.

REVOCATION: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this Authorization I must do so in writing and present my written revocation to the health information management department. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

DURATION: Unless otherwise revoked, this Authorization will expire on the following date, event or condition: _____ OR in the absence of listed date, shall remain valid for 1 year from date of signature.

The covered entity cannot require the patient to sign the authorization in order to receive treatment or payment or to enroll or be eligible for benefits.

RE-DISCLOSURE: I understand that authorizing the disclosure of this health information is voluntary and that I am entitled to a copy of this authorization and acknowledge receipt of a copy thereof. I can refuse to sign this Authorization. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Signature of Patient or Legal Representative Date

_____

If Signed by Legal Rep., Relationship to Patient (please print)

"Insurance Code 1879.2 – Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison." "For your protection California law requires the following to appear on this form."