AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information consistent with state and federal laws concerning the privacy of such information.

Print in ink ◆ Failure to provide *all* information requested may invalidate this authorization.

Use and Disclosure of Health Information

I authorize *Magan Medical Clinic, Inc.*, 420 West Rowland Street, Covina, CA 91723, (626) 331-6411 to:

☐ Provide records to: ☐ Obtain records from: ☐ Make records available for review:

Individual/Agency Name:_____ ☐ Mail ☐ Pick-up

Address_____ City_____ State_____ Zip Code_____

Information To Be Released

☐ Progress Notes Dates of Treatment _____

☐ Immunization Record ☐ Test Results, type and date_____

☐ Other, Specify_____

I specifically authorize release of the following information:_____

☐ HIV test results

Purpose

Purpose/Reason records are to be disclosed:

☐ Continued Care ☐ Personal Use ☐ Insurance ☐ Other, Specify_____

Unless otherwise revoked, this authorization will expire on the following date, event or condition_____. If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date of signature. Signing this form is voluntary. I understand I have the right to revoke this authorization and the right to inspect or get a copy of the material to be disclosed. See reverse side for details on disclosure of information and my rights. I have read both sides of this form and voluntarily authorize and request the disclosure above. I authorize use of a copy (including facsimile copy) of this form for disclosure of the information described above.

Patient Name:_____ SSN:_____

Last First M.I.

Birth Date:_____ Phone Number: (____)_____

Signature, Patient or Legal Representative:_____ Date:_____

Relationship to Patient (if signed by Legal Representative) Witness

Magan Medical Clinic, Inc.
420 West Rowland Street
Covina, CA 91723

Patient Identification:
Name_____
MRN DOB

Authorized Agent:
Knox Attorney Service, Inc./ Knox Services LLC.