HIPAA COMPLIANT MEDICAL AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name of Patient _____ **D.O.B.** _____

Patient Social Security _____ **Maiden Name** _____

Patient Home Phone Number _____ **Work Phone Number** _____

Name of Physician and/or Hospital _____

Address _____ **City** _____

State/Zip _____ **Phone Number**_____

Fax Number _____

The undersigned hereby authorize the release of all medical documentation and other information, including protected health information that I could personally obtain upon request, which may be in the possession of any health care provider, medical care facility, insurer, physician, hospital, ambulance service or nurse or any other covered entity under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to:

Dr. David A Steenblock, D.O
26381 Crown Valley Parkway Suite #130
Mission Viejo, Ca 92691
Phone: (800) 300-1063/(949) 367-8870
Fax: (949)367-9779

I intend the person(s) listed above to have authority to gain immediate access to my medical records.

Upon presentation of this authorization (or a photocopy), you are authorized to release a copy of these records to any person who is my personal representative. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the personal representative and may no longer be protected by federal law.

The purpose of the disclosure is to enable the person(s) named above to fully act as my personal representative under HIPAA, including the ability to access and re-release my medical records. This authorization shall be deemed to comply with all requirements of HIPAA (45 CFR Section 164).

This authorization shall become effective on the date it is signed and expire two years after my death. I understand that I may revoke this authorization at any time, without regard to my mental or physical condition, by sending written notice to my medical providers or by using any method capable of revoking a health care agency under California law.
Signature of person authorizing disclosure:

Dated on this date: _____

Patient's Signature: _____

Witness Signature: _____

* CT Scans
* MRI's
* Spec Scans
* Ultrasound Carotid
* Discharge Summary
* Nuerological Disorder: Brain Reports
* Lab Reports

In furtherance of this authorization, we do hereby waive all provisions of law and privileges relating to the disclosure hereby authorized.