



AUTHORIZATION FOR REQUESTING RECORDS FROM FACILITIES OUTSIDE OF MARATHON MEDICAL GROUP

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization.

EXPLANATION

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Name of Patient:	
Date of Birth:	SSN:

REQUESTING RECORDS FROM

I hereby authorize:

Name/Facility:	Attention:
Address:	Phone:
City: State: Zip:	FAX:

SENDING RECORDS TO

Marathon Medical Group	Attention: Medical Records
500 S. Anaheim Hills Rd, Suite 206	Phone: 714-282-6934
Anaheim Hills, CA. 92807	FAX: 714-282-6935

INFORMATION TO BE RELEASED (Only check one box in this section)

- Pertinent Information: **(This is what most patients and physicians need)**
2 years of Progress Notes, Labs, History and Physical; 5 years of Diagnostic Test Results (Radiology and Special Testing)
- OR All health information pertaining to my medical history, mental or physical condition
- OR Only the following records or types of health information:

Specify the Date or Time Period For the Information Above:
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AUTHORIZATION TO RELEASE STATUTORILY PROTECTED INFORMATION

I specifically authorize release of the following information (check and initial as appropriate):

<input type="checkbox"/> Mental health treatment information	Initial if requesting:
<input type="checkbox"/> HIV test results	Initial if requesting:
<input type="checkbox"/> Alcohol/drug treatment information	Initial if requesting:

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.



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PURPOSE

Purpose of requested use or disclosure:

- Patient Request Continuing Care Legal
 Insurance Other _____

EXPIRATION

This Authorization expires [insert date]: _____

If no Date is given; this authorization will expire 6 months from the signature date.

MY RIGHTS

I may refuse to sign this Authorization. If you refuse to sign this Authorization, please know that by law, your health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the address specified in the "REQUESTING RECORDS FROM" section above.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of this Authorization.

Copy requested and received:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Initial:	Date:
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SIGNATURE

Patient Signature:	Date:
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Legal Representative Signature: (Patient representative/spouse/financial responsible party)	Date:
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If signed by someone other than the patient, state your legal relationship to the patient and why you have the authority to act for the patient:
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Witness Signature:	Date:
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