Provider 1ST

HIPAA AUTHORIZATION FORM

_____ _____

Patient's Full Name | Patient's Social Security Number/Medical Record Number

_____ _____

Adress | Pateint's DOB (MM/DD/YYYY)

_____ _____

City,State Zp Code | Patient's Telephone Number

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
2. The following person (or class of persons) may receive disclosure of protected health information about me:

   His/Her/its Name _____

   Address (with city, stats, zip code) _____

3. The specific information that should be disclosed is (please give dates of service if possible):

4. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including , and not limited to : Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501) Drug abuse, alcoholism, or other substance abuse, Sickle cell anemia. Records which may indicate the presence of a communicable or no communicable disease; and tests for or records of HIV/AIDS, Gene-related impairments (including genetic test results)
5. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
6. I may revoke this authorization by notifying_____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
7. My purpose/use of the information is for_____ .
8. I understand this authorization will expire 90 days from the date of this authorization, OR upon occurrence of the following event/date that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with Recordflow to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.
THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

_____ _____ _____

Signature of Individual* | **Date of Individual's Signature** | **Date of Birth or Social Security Number**

(The person about whom the information relates)

Note: There may be a fee associated with your request, if so, an invoice will be included with the records.

FAX **Fax to:** (800) 818-2114

MAIL **Mail To:** P.O.BOX 54650 Irvine, CA 92619

@ **Email to:** requests@provider1st.com

Questions call us: (855) 514-2378