Jones & Jones Medical Associates, Inc.
18660 US Hwy 18
Apple Valley, CA 92307

Date: _____ Print Form

Authorization to Release or Receive Protected Health Information

I authorize: **Person or facility releasing Protected Health Information**

Name: _____ DOB: _____ ID#: _____

Address: _____ State: _____ Zip Code: _____ E-Mail _____

Additional Information: _____

Person or Facility Authorized Protected Health Information will be released to:

Name: _____ DOB: _____ ID#: _____

Address: _____ State: _____ Zip Code: _____ E-Mail _____

Additional Information: _____

Protected Health Information to be released

☐ Medical records ☐ Mental Health Records*

☐ All Medical Records ☐ Limit to Specific Information

☐ Include Billing Records Date of service _____

☐ Consutations From: _____ To: _____

☐ Diagnostic Imaging

☐ Emergency Medicine

☐ Immunization Records

☐ Laboratory Reports

☐ Progress Notes

☐ Drug/Alcohol 42 CRF, Part 2 Initials_____

☐ HIV/Aids Initials_____

☐ Paternity Tests Initials_____

☐ Psychological Initials_____

☐ STD Test Results Initials_____

Purpose _____

Note: If all medical records box is checked, any and all information included in your file may be released to the recipient.
If specific Information is checked, only the information selected will be released to the recipient.
Mental Health records cannot be combined with a patients medical record. A separate authorization is required for mental health records

GENERAL AUTHORIZATION: This release applies to any individually identifiable health information (Protected Health Care Information) governed and protected by the Health Insurance Portability and Accounting Act of 1996 (HIPAA), as amended, and under the rules and regulations thereunder. I, the undersigned patient or legal representative, hereby authorize the above named Medical Information Holder to use, review, give, disclose and release the health, medical, and mental health information and related records for the patient named above, and as specified below, to the recipient(s) named above. Method of release shall be pertinent to the need and may include photocopies, photographs, fax copies, scanned copies, postal mail, express mail, computer files, e-mail, personal review, inspection, audio, telephone, video, electronic, or verbal communication.

This authorization shall supercede any prior written authorization I have made regarding the use, release and disclosure of my medical information. I may revoke this authorization at any time, by written notice, except to the extent that action has already been taken to comply with it. Unless expressly revoked or otherwise terminated by expiration date listed below, this authorization will automatically expire upon fulfilling the purpose or need for information as specified above, or as limited by law. This authorization shall not be affected by my death, disability or incapacitation.

If not the Patient, Name of Person signing form:

Print Name _____ Relationship: _____

Signature of Patient or Representative authorized by law

If left blank expires in 1 year

Signed: _____ Date: _____ Expiration Date _____