Authorization for Use or Disclosure of Protected Health Information

Newport Beach Medical Associates
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As required by the Health Insurance Portability and Accountability Act of 1996(HIPAA) and California Law, Newport Beach Medical Associates (hereafter referred to as "NBMA") may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You have a right to copy of this form.

This authorization is limited to the following medical records and type of information:

☐ Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act*, drug and/or alcohol abuse records and/or HIV test results, if any except as specifically provided below:

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☐ All psychotherapy notes may be released, except as specifically provided below:

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The information may be used only for the following purposes (if you do not wish to explain the purpose, write "At the request of the individual"):____

- I understand that I may revoke this authorization at any time by notifying NBMA in writing. My revocation will not affect actions by NBMA prior to its receipt.
- I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under CA law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.
- I understand that treatment, payment or continued enrollment in a health plan or eligibility for benefits will not be conditioned upon provision of authorization.

This authorization is effective now and will remain in effect until:

☐ ____(Event or Date)

I,____, hereby authorize NBMA to release my health history information.

(**PRINT NAME**)

Date of Birth:__________________________ Reason for copying records: ☐ New Doctor ☐ Personal Use*(fee)

If records are for a new doctor then an address needs to be provided or records will be sent to the patient.

Address Transferring to:

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Preferred method of Delivery: ☐ Mail ☐ Pick-UP at NBMA *Paying BY: ☐ Check ☐ Money Order or ☐ Cash

There is a **$25.00** fee for copying records for personal use. Please remit payment payable to ***Integrated Business Solutions.***

Patient Signature:____ Date:__________________

Current Address:____

*For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further, the LPS Act often requires that both the patient's treating physician and the patient sign the authorization form before information may be released. Under HIPAA, an authorization for release of psychotherapy notes may not be combined with an authorization involving any other type of health information (except psychotherapy notes).

***Person(s) I am authorizing to pick up my medical records**:

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