CEI Medical Group

ear • sleep • sinus • face

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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.

Name of patient: _____ DOB:_____ Phone:_____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____
To release to:

Name_____

Address _____

Phone/Fax _____

Patients
Initials
_____ Patient requests records to be faxed to another facility or physician's office. Patient is aware of confidentiality risks involved and releases CEI Medical Group from responsibility for this fax.

The following information is to be released:
a. □ Assessment/History and Physical – Date(s) of Service: _____
□ Discharge Summary – Date(s) of Service: _____
□ Lab Tests – Date(s) of Service: _____
□ Radiology Reports – Date(s) of Service: _____
□ Entire Record – Date(s) of Service: _____
□ Other (please specify needed information and date(s) of service if known): _____
_____

b. I specifically authorize the release of the following information (check as appropriate):
□ Mental health treatment information 1. (A separate authorization is required to authorize the Disclosure or use of psychotherapy notes.)
□ HIV test results
□ Alcohol/drug treatment information

Patients
Initials
_____ I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization, I am authorizing the release of such information unless specified otherwise above.

PURPOSE:
The purpose of the release of this information is:
□ Insurance or other third party reimbursement

1900 University Avenue, Suite 101
E. Palo Alto, CA 94303
Telephone (650) 494-1000
Fax (650) 322-8228

□ Continuity of medical care
□ Pending legal action
□ At the request of the patient
□ Other: (Specify) _____

RESTRICTIONS:
According to federal and state regulations, if the medical information requested relates to AIDS/HIV treatment or treatment in a federally recognized chemical dependency unit, then the information will be accompanied by a statement limiting disclosure to third parties as required by law.

I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above my be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that the office and its employees have a responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The office will not be held responsible for any subsequent disclosure by the recipient of the health information. I release CEI Medical Group and employees of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. 2.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. Please inquire at billing@calear.com if you wish to obtain your records electronicially.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

CEI Medical Group
1900 University Ave., Suite # 101
East Palo Alto, CA 94303

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 hard or electronic copy of this authorization. 3.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient.

If this box □ is checked, the requester will receive compensation for the use or disclosure of my information. 4.

There is a $35.00 processing fee for medical records, plus an additional $35.00 per x-ray or CT. You may pay by check, debit card, Visa or MasterCard.

SIGNATURE

Date: _____

Time: _____ am/pm

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Signature: _____

(Circle one: patient / representative / spouse / financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:

_____

_____

Witness: _____

_____

1. If mental health information covered by the Lanteman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.

2. If any of the HIPAA-recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition, treatment, health plan enrollment, or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

3. Under HIPAA, the individual must be provided with a hard or electronic copy of the authorization when it has been requested by a covered entity for its own uses and disclosures.

4. The requester is to complete this section of the form.

ceimedicalgroup.com

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