



# SELARZ LAW CORP.

11777 SAN VICENTE BLVD., SUITE 702  
LOS ANGELES, CALIFORNIA 90049  
TELEPHONE: 310.651.8685  
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## AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION (HIPAA COMPLIANT)

NAME: [Client's Name] DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY NO.: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to release health information to: Selarz Law Corp., 11777 San Vicente Blvd., Suite 702, Los Angeles, California 90049.

I further authorize Selarz Law Corp., or its representatives, agents, and/or photocopy service agents, to obtain a copy of such records as are needed for the purpose below.

### TYPE OF RECORDS

MEDICAL       MENTAL HEALTH

### INFORMATION TO BE RELEASED:

- |  |   |
|--|---|
| <input type="checkbox"/> Discharge Summary                     | <input type="checkbox"/> Laboratory/Pathology Records |
| <input type="checkbox"/> Emergency Medicine Report             | <input type="checkbox"/> Dental Records               |
| <input checked="" type="checkbox"/> Billing Statements         | <input type="checkbox"/> Operative Reports            |
| <input type="checkbox"/> History & Physical Exams              | <input type="checkbox"/> Outpatient Clinic Records    |
| <input type="checkbox"/> Radiology/Diagnostic Reports          | <input type="checkbox"/> Radiology/Diagnostic Images  |
| <input type="checkbox"/> Drug and Alcohol Abuse Information    | <input type="checkbox"/> HIV/AIDS Test Results        |
| <input type="checkbox"/> Psychological/Vocational Test Results |   |
| <input checked="" type="checkbox"/> Any and All Records        |   |
| <input type="checkbox"/> Other _____                           |   |

For the period \_\_\_\_\_ to present.

### THE PURPOSE OF THIS RELEASE IS:

- At the request of the patient/patient representative  
 Other (state reason): \_\_\_\_\_

### NOTICE:

I understand that organizations and individuals such as physicians, hospitals and health plans are required by law to keep my health information confidential. I further understand that if I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

**MY RIGHTS:**

I understand that this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: (1) conducting research-related treatment; (2) to obtain information in connection with eligibility or enrollment in a health plan; (3) to determine an entity's obligation to pay a claim; or (4) to create health information to provide to a third party.

I understand that I am entitled to receive a copy of this Authorization.

I further understand that I have the right to revoke this authorization by presenting written notice to Selarz Law Corp., who I authorized to obtain my records prior to it submitting its request to the entity listed above. I further understand that any revocation notice will not apply to actions taken by Selarz Law Corp. prior to the date it received my written request to revoke authorization.

I understand the contents of this written authorization in its entirety and have asked questions about anything that was not clear to me, and I am satisfied with the answers I have received.

**A PHOTOSTATIC OR FACSIMILE COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL**

**EXPIRATION OF AUTHORIZATION:**

**Unless otherwise revoked, this authorization shall remain valid for three years from the date below.**

Signature of the Patient or Patient's Legal Representative

By: \_\_\_\_\_  
[Client's Name]

Dated: \_\_\_\_\_