SELARZ LAW CORP.

11777 SAN VICENTE BLVD., SUITE 702
LOS ANGELES, CALIFORNIA 90049
TELEPHONE: 310.651.8685
FAX: 310.651.8681

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION (HIPAA COMPLIANT)

NAME: [Client's Name] **DATE OF BIRTH:** _____

SOCIAL SECURITY NO.: _____

I hereby authorize *PLEASE LEAVE BLANK* 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:

☐ Discharge Summary
☐ Emergency Medicine Report
☒ Billing Statements
☐ History & Physical Exams
☐ Radiology/Diagnostic Reports
☐ Drug and Alcohol Abuse Information
☐ Psychological/Vocational Test Results
☒ Any and All Records
☐ Other _____
☐ Laboratory/Pathology Records
☐ Dental Records
☐ Operative Reports
☐ Outpatient Clinic Records
☐ Radiology/Diagnostic Images
☐ HIV/AIDS Test Results

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: _____ Dated: _____
[Client's Name]