Custodian of Records: Pursuant to AB 1337, effective January 1, 2016, **all** medical providers are now required to accept this signed and completed authorization form in California for the disclosure of health information. (See https://leginfo.legislature.ca.gov/ for full text of the bill.)

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION
PURSUANT TO EVIDENCE CODE SECTION 1158

The undersigned authorizes the medical provider designated below to disclose specified medical records to a designated recipient. The medical provider shall not condition treatment, payment, enrollment, or eligibility for benefits on the submission of this authorization.

The disclosure of records authorized herein is required for the administration of a claim.

Medical provider: ____

Patient name: ____
Medical record number: ____
Date of birth: ________________
Address: ____
Telephone number: ________________ Email:_______________________________________

Recipient name: Lexitas
Recipient address: PO Box 3010 Rocklin, CA 95677
Recipient telephone number: 800-497-7618

Health information requested (check all that apply):
___Records dated from ________ to ________.
___Radiology records: ______ images or films ______ reports ______ digital/CD, if available.
___Laboratory results dated.
___Laboratory results regarding specific test(s) only (specify)___________________________.
___All records.
___Records related to a specific injury, treatment, or other purpose (specify):_______________.
___Any and all Pharmacy records
___Any and all Insurance records

Purpose: For Administration of Claim.

Note: records may include information related to mental health, alcohol or drug use, and HIV or AIDS. However, treatment records from mental health and alcohol or drug departments and results of HIV tests will not be disclosed unless specifically requested (check all that apply):

___Mental health records.
___Alcohol or drug records.

___HIV test results.

Method of delivery of requested records:
___Mail
___Pick up
___Electronic delivery: rwd.records@lexitaslegal.com

This authorization is effective for one year from the date of the signature unless a different date is specified here: ________________.

This authorization may be revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request.

A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization.

Notice: Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I certify that this medical release authorization was printed in 14-point type when I signed it.
I have received a copy of this authorization.

Patient signature*: ____
Date: ________________
Print name: ____

*If not signed by the patient, please indicate relationship to the patient (check one, if applicable):

___Parent or guardian of minor patient who could not have consented to health care.
___Guardian or conservator of an incompetent patient.
___Beneficiary or personal representative of deceased patient.