Authorization for Release of Protected Health and/or Personal Information

1. Authorization: I authorize disclosure of Protected Health and/or Personal Information as described below:

Records of: Name _____ Date of Birth _____

Address: _____

Social Security Number:_____-____-_____ Phone (____)_____

2. Record Holder: See attached history on page 3
(Name of Location holding Records / Disclosing Party)

3. Records May Be Released To: c/o Lexitas
(Name of Requesting Party and/or Agent)

PO Box 3010	Rocklin	CA	95677
Street Address	City	State	Zip

4. Type of Information: This authorization allows for the release/disclosure of records pertaining to, but not limited to: Any and all medical records, files, reports, charts, graphs, notes, tests, MRI's, X-Rays, lab reports, billing, Employment, Scholastic, Union records, personnel, attendance, pension, transcripts, wage and insurance information, earnings and employment from Social Security Administration, EDD Disability and Unemployment records, Insurance and Claim records, Police, Prison and Probation records, unless otherwise listed below.

☐ Other (Please Specify)_____

Specific Confidential Records Release/Disclosure: Please initial all that apply

____Genetic Records ____Treatment for Alcohol and/or Drug Abuse

____HIV Test Results ____Psychiatric / Mental Health Records

____Other (Please Specify)_____

5. Date Range/Treatment Dates: Unless specified below, Patient is uncertain of specific dates and/or is approving release of any and all records in possession of the Record Holder cited above: **From _____ To _____**

6. Use of Information: The individual or entity identified above is permitted to use my information for the following purposes: **Please mark all that apply**

☐ Claim Administration ☐ Other (Please specify)_____

7. Duration: This Authorization is effective immediately and shall remain in effect until one year from the date signed below, unless another date is specified here: _____

8. Additional Copy: I further understand that I have a right to receive a copy of this authorization upon my request.

9. Redisclosure: I understand that once received, my records will be subject to re-disclosure and may no longer be protected by federal privacy laws. State or other federal law may require the recipient to obtain your authorization before further disclosure.

10: Revocation: Unless otherwise provided by federal or state law, I understand that I may revoke this authorization at any time by notifying, in writing, to _____at _____, of my revocation and that my
(Requesting Party) (Requesting Party address)
revocation shall be effective upon 's receipt of my notice of revocation. I also understand that my revocation of the Authorization will not have any effect on any actions taken by_____ before it receives my revocation.
(Requesting Party)

11. Explanation: I understand this authorization is voluntary. Treatment,payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

12. Signature:
Printed Name:_____
_____
Signature:_____Date/Time:_____

If other than patient, indicate relationship to patient: _____

For your protection California law requires the following to appear on this form: Any person knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Please list any medical providers, hospitals, clinics, insurance companies, employers along with any information you have (i.e names, addresses, phone numbers, dates of treatment/employment/claims) within the last 10 years. ***Also, make sure you have signed and initialed, where applicable, the preceding authorization, pages 1 and 2.**

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