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Authorization to Use, Disclose, and/or Receive Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the transfer of health information described below. **Please review and complete this form carefully. It may be invalid if not fully completed**.

You may also request that your records be transferred to the new physician you select.

Patient name: _____ Date of birth: _____ Today's date: _____

Address:

If patient is <18 years old, print name of parent/guardian completing/signing form: _____
Check box that applies: ☐ Parent ☐ Guardian

Records to be transferred: I would like the following to be transferred

☐ All records or ☐ The portion of the records concerning: _____
(Specify type of disease, dates of treatment, or other portion of records.)

Please transfer these records to: (Name of provider, address, phone number and secure fax number to whom this record should be delivered). **Fax number is required.**

Charges: I understand that you may charge me a reasonable charge of up to $0.25 per page or $0.50 per page for copies from microfilm, plus any additional reasonable clerical costs incurred in making the records available.
I understand that transferring records from one health care provider to another does not incur a fee.

☐ I hereby agree to pay the charges specified above. ☐ Please bill my credit card on file. There is a $5 additional fee.
☐ Please bill me.

☐ Please call me to let me know how much these copies will cost.

Signed: _____ Date: _____

Print name: _____ Telephone _____