Authorization to Release HIPAA Protected Health Information

I authorize Cynthia Orrego, Ph.D. and her administrative staff to release or obtain medical or clinical records regarding:

Patient's Name:
Date of Birth:
Address:

This information should only be obtained/released to/from (name, address and telephone number of person to whom the information is to be released or obtained):

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I am requesting Dr. Cynthia Orrego to release or obtain the following:

Admission____	Diagnostic Tests_____	Anesthesia Record____
Discharge Summary_____	Lab____	Progress Notes_____
Emergency Rm. Records____	Imaging/Radiology____	Physician Orders_____
History & Physical____	Cardiac Studies_____	Pathology Reports_____
Consult Report(s)_____	Face Sheet______	Other____________________
Operative Records_____	Medication Record_____	Psychological Reports____
Psychiatric Records____	School Record(s)_____	School Discipline Report____

This authorization shall remain in effect from ______________to _________________
You have the right to revoke this authorization in writing, at any time by sending such written notification to Dr. Orrego's office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand the information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

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Signature of Patient/Guardian Date

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Relationship to Patient