Kerlan - Jobe Orthopaedic Clinic
Authorization for Use or Disclosure of Health information

The completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth below consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization. Your request will be processed and fulfilled within 4-7 business days from the day it is received.

Fees: $20.00 - records (copy)
$15.00 - per sheet of film

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

_____ _____

I, _____ , hereby authorize Kerlan - Jobe Orthopaedic Clinic to the use and/or disclosure of my health information as follows:

Person/Organizations authorized to use and/or disclose the information: _____

Person/Organizations authorized to receive the information: _____

Address of person/organization to receive the information: _____

This authorization applies to the following information:

_____ Entire record _____ These specific dates only: _____

_____ X-Ray films Dates: _____

Purpose of use or disclosure of information:

_____ To comply with court order _____ Required for insurance claim _____ Application for insurance

_____ For personal use _____ Payment of a bill _____ Other _____

_____ For follow-up care _____ To update medical records _____

Expiration: _____ (This authorization expires-insert date/event)

Restrictions: California law prohibits the requestor from making further disclosures of my health information, unless the requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

Patient's rights:

- I further understand that I have a right to receive a copy of the authorization upon my request
  Copy requested and received: ☐ YES ☐ NO _____ INITIAL
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to the following address: _____
- My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization.
- I have right to receive a copy of this authorization.

SIGNATURE:

Date: _____ Time: _____ AM/PM

Signature: _____
(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient state your legal relationship to the patient:

Witness: _____

(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.)

Correspondence Desk
Medical record Department
Tel: (310) 665-7249
Tel: (310) 665-7281
Business hours 8:00am to 4:00pm

6801 Park Terrace, Los Angeles, CA 90045
(310) 665-7200