AUTHORIZATION FOR RELEASE OF INFORMATION

SECTION A: Must be completed for all authorizations.

I hereby authorize the use/disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is as valid as the original.

Patient Name: ______________________ Date of Birth: ______________________

Person(s)/organizations authorized to use/disclose information (from): Ventura Pulmonary and Critical Care Medical Group
168 N. BRENT ST., #406
VENTURA, CALIFORNIA 93003

Person(s)/organizations authorized to receive the information: ______________________

Information that may be used/disclosed:
(Include dates where appropriate, e.g., medications dispensed in December 2011 or EKG Report performed in May 2011)

- ❑ Record of Visits (all) ______
- ❑ Record of Visit(s) (Specific) ______
- ❑ Discharge Summary ______
- ❑ History/Physical ______
- ❑ Consultation Report(s) ______
- ❑ Operative Report(s) ______
- ❑ Problem List ______
- ❑ Progress Notes ______
- ❑ Immunization Record(s) ______
- ❑ Medication Record(s) ______
- ❑ Laboratory Report(s) ______
- ❑ X-Ray, MRI, CT ______
- ❑ Echo, Stress Tests, Holters ______
- ❑ EKG Report ______
- ❑ Mental Health/Alcohol/Drug Abuse Treatment ______
- ❑ AIDS or HIV Information ______
- ❑ Hepatitis Information ______
- ❑ Entire Medical Record ______
- ❑ Statement of Charges/Payments ______
- ❑ Other ______

SECTION B: Must be completed only if a health provider or a health plan has requested the authorization.

1. The health plan or health care provider must complete the following:

   a. The information will be used/disclosed for the following purposes:

   - ❑ Continued Patient Care
   - ❑ Disability Determination
   - ❑ Personal Use
   - ❑ Attorney/Legal
   - ❑ Insurance Claim
   - ❑ Other ______

   b. Will the health care provider or health plan requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes ______ No ______

2. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

3. I understand that I may inspect and copy any information to be used or disclosed.

SECTION C: Must be completed for all authorizations.

1. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires ______________________
   (Insert applicable date or event that triggers expiration)

2. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

______________________ ______________________
Signature of Patient or Representative — Today's Date

______________________ ______________________
Printed Name of Patient's Representative (if applicable) — Relationship to Patient