EastBayHand Medical Center
(510) 297-0550
(510) 297-0558
www.EBHMC.com
13690 E 14th St #200, San Leandro, CA 94578

Authorization to Release Protected Health Information

HIPAA Compliant Request for Information

Name of Patient _____ Street Address _____

Phone Number _____ Fax Number _____ City _____ State _____ Zip Code _____

Email Address (please print clearly) _____ Date of Birth (00/00/0000) _____ Last Four of SSN _____

I hereby give the following person(s) or entity permission to release my Protected Health Information (PHI):

East Bay Hand Medical Center
13690 E. 14th Street, Suite 200
San Leandro, CA 94578

Please choose the method of delivery by checking the preferred option and filling in the information where required. Be certain that information is accurate and complete. Incomplete authorizations are invalid.

____ Please email me the records.
(Records will be sent to the email address listed above)
(Email recommended for fastest delivery of records)

____ U.S. Mail to my personal address.
(Records will be mailed to address listed above)

____ I prefer to pick up my records personally.
Please call me when they are ready.
(Photo ID will be required for pick up)

____ Please send my records to the following:

Name of medical office/Company/Entity you want to receive the records. _____

Street Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

The Protected Health Information (PHI) I would like to have released is as follows:

____ Release an abstract of my PHI (two (2) year summary)

____ Release my entire chart (subject to state regulated per page fees)
(You will receive an invoice. Records are not released until invoice is paid in full.)

____ I would like specific dates of service _____

Please provide the purpose of your request _____

This authorization shall expire ninety (90) days from the date of signature, or at the following event: _____

I am requesting my PHI to be disclosed for the following reason: _____

I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from redisclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be redisclosed by the recipient and may no longer be protected by law. I understand that this authorization will expire in 90 days from the date of my signature. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

Signature of Patient _____ Date _____

Signature of Parent/Guardian or Personal Representative (attach proper documentation) _____ Date _____