AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Authorization for Use/Disclosure of Information: I authorize Dr. Diane Danis, M.D., M.P.H. to disclose health information for myself/my child _____ to the recipient(s) identified below:

Recipient Name:_____ Email: _____

Recipient Name: _____ Email: _____

Recipient Name: _____ Email: _____

Information to be disclosed: I authorize the release of the following health information:

____ All information relating to my/my child's medical history, mental or physical condition and treatment

____ Only the following records or types of health information:

_____

Term: I understand that this Authorization will remain in effect for **one year** from the date of this Authorization.

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my/my child's health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Electronic transmission of medical information: I understand that Dr. Danis will only send medical records electronically. All medical records are sent via a secure HIPAA compliant server called Send, Inc. **You MUST download the records within 5 days of receiving them electronically**, otherwise they will disappear from the website. Once this authorization is received, you will be sent an e-mail explaining how the system works.

Right to Revoke: I understand that I can revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. The revocation will be effective immediately upon the health care provider's receipt of written notice. The revocation will not have any effect on any action taken by my health care provider in compliance with this Authorization before receiving this written notice of revocation.

Questions: I may contact Dr. Danis for answers to my questions about the privacy of health information at P.O. Box 90726, Pasadena, CA 91109.

I have read the above authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature: _____Date:_____

Name of Guardian/Representative: _____Date: _____

Legal Relationship: _____