Head and Neck Associates of Orange County, Inc.

AUTHORIZATION FOR USE / DISCLOSURE OF HEALTH INFORMATION

Under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), completion of this form authorizes Head and Neck Associates of Orange County, Inc., to use / disclose my health information as designated below.

☐ The person / people authorized to make this use / disclosure request is / are:

_______________________________________ _______________________________

(Print Name of Patient / Guardian of Minor Child) (Relationship to Patient)

I hereby request access to health information for the following named person:

_______________________________________ _______________________________

(Print Patient's name) (Patient Date of Birth)

SCOPE OF ACCESS REQUESTED

I would like access to: ☐ All the records (excluding Substance Abuse, Mental Health, HIV Diagnosis / Treatment)

or ☐ The portion of the records concerning:

____

____

(Specify type of disease, accident, dates of treatment, or other portion of records you are interested in.)

I also consent to the specific release of the following records:

☐ Drug/Alcohol/Substance Abuse ______(initial) ☐ HIV Diagnosis/Treatment ______(initial)

☐ Psychiatric/Mental Health ______(initial) ☐ Genetic Information _______(initial)

☐ Tests for Antibodies to HIV ______(initial)

This authorization shall be effective immediately and remain in effect until: ___________ (Date)

TYPE OF ACCESS REQUESTED ☐ Inspection. Please let me know when I may come to inspect the records, and the amount of the charge, if any.* I understand that an employee of Head and Neck Associates or Orange County will be present and that I may not make any marks or alter the records in any way.

☐ Copies. I would like copies of ☐ All records requested ***or*** ☐ The portion of the record noted above

☐ Transfer. Please transfer ☐ All records requested ***or*** ☐ The portion of the record noted above

To: ____

____

(Name and address of person / health care provider to whom the records are to be delivered)

I would like the information delivered via the following format:

☐ Paper copy: U.S. mail ☐ Paper copy: office pick up (Mission Viejo location only) ☐ FAX Number: _____________

P: (9490 364-4361 • FAX: (949) 364-4495 • www.hnaoc.com

Head and Neck Associates of Orange County, Inc.

An Incorporated Medical Group

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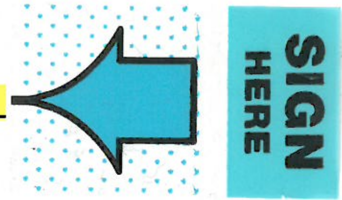
CHARGES (if applicable):

Inspection. I understand that you may charge me for reasonable clerical costs incurred in making the records available for inspection at a rate of $6.00 per quarter hour and I may be required to pay these costs before I may inspect the records.*

Copies or Transfer. I understand that you may charge me a reasonable charge of up to twenty-five cents ($0.25) per page, or fifty cents ($0.50) per page for copies from microfilm, plus any additional reasonable clerical costs incurred in making the records available. *

☐ I hereby agree to pay the charges specified above. Please bill me. ☐ Please call me to let me know how much these copies will cost. ☐ I am requesting these records be provided without charge to appeal the denial of eligibility for Medi-Cal, SSDI or SSI/SSP benefits. A copy of the program's denial notice is attached. I applied for these benefits on ______________________________(date).



Signature: ________________________________ **Date:** _____/_____/____________

Print Name: ______________________________ **Telephone:** ______________________

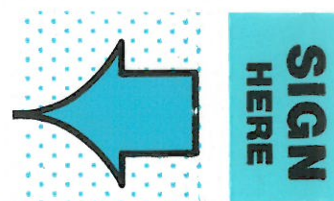
If not signed by the patient, please indicate relationship:

☐ parent or guardian of minor patient ☐ guardian or conservator of an incompetent patient

☐ beneficiary or personal representative of deceased patient

HIPAA NOTICE OF RIGHT TO REVOKE:

Under the privacy rules, I have the right to revoke this authorization at any time and that Head and Neck Associates of Orange County, Inc., must cease using this authorization. However, Head and neck Associates of Orange County, Inc., may complete any actions it initiates prior to my revocation and which rely on my health information for completion. I must revoke this Authorization in writing and send the revocation to: Head and Neck Associates of Orange County, Inc., 26726 Crown Valley Pkwy. #200, Mission Viejo, CA. 92691. I understand that by disclosing my health information, Head and Neck Associates of Orange County, Inc., cannot guarantee the recipient will not use or disclose my health information in violation of the Privacy Rules. I understand that I have a right to receive a copy of this signed authorization. A photocopy and / or facsimile of this authorization shall be considered as effective and valid as the original.



Signature: __________________________________ **Date:** ____/____/__________

Print Name: ______________________________ **Relationship to Patient:** ______________________

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