AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____
Date of Birth _____ SS# _____
I authorize the release of Health Information to:

Dr. Steven C Eggleston, D.C.
2601 Main St., STE 800, Irvine, CA 92614
(877) 424-4765 - Fax (877) 883-2963
Email to: Dr.Eggleston@yahoo.com

INFORMATION TO BE RELEASED

_____ Complete Medical Record Including Billing Statement and Reports

_____ Billing Statements
_____ Laboratory Reports
_____ Dental Records
_____ Pathology Reports/Records
_____ Diagnostic Imaging Reports
_____ Discharge Summary
_____ Emergency Medicine Reports/Records
_____ History & Physical Exam Reports/Records
_____ Operative Reports/Records
_____ Diagnostic Imaging Films

SPECIFIC AUTHORIZATIONS

_____ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment (42 C.F.R. §§ 2.34 and 2.35)
_____ I specifically authorize the release of information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§ 5328, *et seq.*)
_____ I specifically authorize the release of HIV/AIDS testing information (Health and Safety Code § 120980(g))
_____ I specifically authorize the release of genetic testing information (Health and Safety Code § 124980(j))

THE PURPOST OF THIS RELEASE IS (check one or more)

_____ Continuity of care or discharge planning
_____ Billing and payment of bill
_____ At the request of the patient/patient's representative
_____ Review of records
_____ Other (state reason) _____

NOTICE

Health Care Providers and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep health information confidential. 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 by state or federal confidentiality laws.

MY RIGHTS

I understand this authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: (1) conducting research-related treatment; (2) obtaining information in connection with eligibility or enrollment in a health; (3) for determining an entity's obligation to pay a claim; or (4) creating health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.

I may revoke this authorization at any time, provided that I do so in writing and submit it to: DR. STEVEN C EGGLESTON, D.C. The revocation will take effect when received by DR. STEVEN C EGGLESTON, D.C., except to the extent that DR. STEVEN C EGGLESTON, D.C. or other have already relied on it.

I am entitled to received a copy of this Authorization

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization expires _____ *(insert applicable date or event). If not date is indicated, this authorization will expire 36 months after the date of signing this form.*

SIGNATURE

_____ _____
(Signature of Patient or Patient's Legal Representative) Date

_____ _____ AM PM
Printed Name Time

_____
(Legal Relationship of Signatory if not Patient)

_____
Signature of Witness or Translator