

RECORDS RELEASE FORM

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the release of medical records. Covered entities, as that term is defined by HIPAA and relevant state law, must obtain a signed authorization from the individual or the individual's legally authorized representative to disclose that individual's PHI. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law.

Information regarding the patient for whom the authorization is made:

Patient Name: _____
Date of Birth: _____
Address: _____
Phone: _____ Email _____

Release my information from:

FOCUS Health Group 448 Ignacio Blvd #294 Novato, CA 94949 P: 415-484-1240 F: 866-484-0518

Release my information to:

Please select all that apply. For release to other healthcare providers a fax number must be included. Electronic formats are free, hard copy formats will be charged a fee of \$35

_____ Myself
Via:
_____ Patient Portal
_____ Fax to: _____
_____ Mail To: _____

Recipient: _____
Address: _____
Phone: _____ Contact Fax: _____

Recipient: _____
Address: _____
Phone: _____ Contact Fax: _____

REASON FOR DISCLOSURE (select all that apply)

_____ I have received notice of Dr. Jacob Leone's office closure and termination of care as my provider effective 11/30/2021 and wish to transfer my records to another provider

_____ I have received notice of Dr. Jacob Leone's office closure and termination of care as my provider effective 11/30/2021 and wish to release a copy of my records to myself.

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. If all health information is to be released, then check only the first item. Your initials are required to release the following information:

All Health Information including mental health records (excluding psychotherapy notes), Drug, Alcohol, or substance abuse records, genetic information (including Genetic Test Results), HIV/AIDS test results/treatment

All Health information EXCLUDING:

Mental Health Records

Drug, Alcohol, or Substance abuse records

Genetic Information including genetic test results

HIV/AIDS Test results/Treatment

The individual signing this form agrees and acknowledges as follows:

Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will NOT be conditioned upon my signing of this authorization form.

Effective Time Period: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): 11/30/2028 .

Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Special Information: This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION ONLY if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

Name: _____ Date: _____

Signature: _____