PATIENT AUTHORIZATION FOR RELEASE PROTECTED HEALTH INFORMATION – DOUGLAS HAMILTON, M.D.

EVERY FIELD IS REQUIRED TO BE FILLED OUT IN ORDER FOR RECORDS TO BE RELEASED.

Date: _____

Patient's Name: _____

Patient's Date of Birth: _____

Last 4 digits of Patient's Social Security Number: _____

By signing this authorization *(check one)*:

[__] I authorize Douglas Hamilton, M.D. use and/or disclose certain protected health information (PHI) about me to the following.

[__] I authorize the following to use and/or disclose certain protected health information (PHI) about me to Douglas Hamilton, M.D.

Name: _____

Address: _____

Telephone Number: _____

Fax Number: _____

This authorization permits Douglas Hamilton, M.D. to use and/or disclose the following individual identifiable health information about me (describe the information to be used and/or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____

The information will be used and/or disclosed for the following purpose:

_____

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire 50 years from today.

When my information is used and/or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization. My written revocation must be submitted to:

Privacy Officer, Douglas Hamilton, M.D.
6325 Topanga Canyon Blvd. #301 Woodland Hills, CA 91367

Signature: _____

Date: _____

Print Name: _____

If Legal Guardian, Your Relationship to Patient: _____

Patient/Guardian to be provided with a signed copy of authorization.

Please fax back to (818) 884-1254