HIPPA COMPLIANT AUTHORIZATION FOR THE RELEASE

OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

Name of Healthcare Provider/organization:

Minas Kochumian M.D. a Medical Corporation

18251 Roscoe Blvd #202 Northridge, CA 91325

Phone: 818/709-5154 Fax: (818)709-5190

Patient Name: _____

Date of Birth: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPPA identified above disclose full and complete protected medical information including the following:

All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient , outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, records received by other medical providers.

All physical, occupational and rehab requests, consultations and progress notes.

All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

All employment, personnel or wage records.

All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study echocardiogram and cardiac catherization results, videos/CDs/ films/reels and reports.

All pharmacy/ prescription records including NDC numbers and drug information handouts/monographs.

All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits.

I understand the information to be released of disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.
I understand that any personal health information or other information released to Minas Kochumian MD, Minas Kochumian MD a medical corporation may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

Describe information not to be disclosed, if any-

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_____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

I understand that I have a right to revoke this authorization by providing written notice to Minas Kochumian M.D. a medical corporation. However, this authorization may not be revoked if this organization, it's employees or agents have taken action on its authorization prior to receiving my written notice, I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Patient Name:_____

Patient signature_____Date_____

If applicable, Legal Representative sign below:

By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representatives: _____

Signature of Legal Representative: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____