

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I voluntarily authorize _____ to release health information to



Non-Profit Volunteer Advocacy
Organization. EI#61-1422369

Compassion In Action- USA
PO Box 383
San Dimas, CA 91773
(626) 967-6800 Fax: (626) 967-6833

Purpose: To determine my eligibility for disability and rehabilitation benefits.

Information to be released:

- Discharge Summary
- Billing Statements
- Pathology Reports
- EKG
- Progress Notes
- Diagnostic Imaging Reports
- Consultations

- Laboratory Reports
- Operative Reports
- Radiology Reports
- Emergency Medicine Reports
- History & Physical Exams
- Outpatient Clinic Records

Specify the date or time period for information selected above: _____

Specific Authorizations:

I also specifically authorize the release of the information checked in the boxes below:

- 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)).

Expiration of Authorization:

Unless otherwise revoked, this authorization expires 12 months after the date of signing this form. You may revoke this authorization at any time by sending a notice in writing to: Compassion In Action - USA, PO Box 383, San Dimas, CA 91773.

Signature

Date: _____

Signature of Patient or Patient's Legal Representative

Date Of Birth

Printed Name

SSN

(If signed by someone other than the patient, state your legal relationship to the patient/authority)

Witness or Translator