Tom Mahendra, M.D., F.A.C.S., F.R.C.S
1331 West Avenue J, Suite 203
Lancaster, California 93534
661.945.4433
LHIsurgery@gmail.com Lisa@lancasterheart.com

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

This authorization allows Dr. Mahendra to release confidential medical records. All sections must be completed for the authorization to be valid. Use "N/A" if not applicable.

Patient Information

Patient Name (last, first, middle) Date of Birth

____

Street Address City State Zip

____

Phone Email

____

Please release my medical information to:

Name of Physician or Medical Facility

____

Address City State Zip

____

Phone Email

____

Purpose of Records Release

___ Health Care
___ Personal
___ Legal
___ Other (please specify): ____

Authorization

I hereby authorize Dr. Tom Mahendra and/or his representative to release information regarding my medical history, illnesses, or injuries; consultations, prescriptions, treatments, diagnoses, or prognoses; including images, correspondence, and/or medical records; by means of mail, email or other electronic methods.

I authorize the release of the information specified below:
___ My health information related to genetics tests and results
___ My health information related to drug/alcohol/substance abuse
___ My health information related to psychological/psychiatric/mental health
___ My health information related to HIV/STD diagnosis and/or treatment
___ My health information related to the following treatment or conditions:

____

___ ALL my health information EXCEPT those pertaining to genetic tests, substance abuse, mental health, and STDs
___ ALL my health information INCLUDING those pertaining to genetic tests, substance abuse, mental health, and STDs

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Authorization Expiration Event or Date

Unless otherwise revoked by the patient, this authorization for the release of protected health information to the above-named individual/organization will expire on the event or date specified below, or 12 months from the date signed.

Expiration Event: _________________________________ Expiration Date: _________________________

Authorization Information

I understand the following:

1. I authorize the use or disclosure of the health information as described above for the purpose listed. I understand this authorization is voluntary.
2. I have the right to revoke this authorization. To do so I understand I must submit my revocation in writing to Dr. Tom Mahendra or his representative.
3. I am signing this authorization voluntarily and understand my health care treatment will not affected if I do not sign this authorization.
4. The party to whom this protected health information is being release and who has been indicated above is prohibited from re-disclosing the health information except with a written authorization or as specifically permitted by Cal. Code §56.10 or required by law (applies within California only).
5. If the party entered above who is the receiver of this information is not a HIPAA Covered Entity or Business Associate as defined in 45 CFR §160.103, the released health information may no longer be protected by federal and state privacy regulations.
6. I have a right to receive a copy of this authorization.
7. Fees may be charged to cover the cost of releasing the health information.
8. I understand that my substance abuse disorder records are protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be redisclosed without my written authorization.

Signature by or on Behalf of Patient

Name of patient (please print): ____

Signature of patient: ____ Date: __________________

Name of personal signing, if not patient: ____

Authorization to sign on behalf of patient: ____

Name of translator (if applicable): ____

Signature of translator (if applicable): ____