

# HEALTHLINE MEDICAL GROUP

15211 VANOWEN STREET, SUITE 105  
VAN NUYS, CA 91405  
FAX: 818-997-3744 PHONE: 818-997-7711

## AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Treatment, payment enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

Please REQUEST Medical information From:

\_\_\_\_\_  
Name of Health Care Provider

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, and Zip Code

I hereby authorize \_\_\_\_\_

Information as indicated below to the health care provider, entity, or person I have indicated above.

Please SEND Medical Information TO:

HEALTHLINE MEDICAL GROUP

\_\_\_\_\_  
Name of Person or Entity to Receive Information

15211 Vanowen St Ste #105

\_\_\_\_\_  
Street Address

Van Nuys, Ca 91405

\_\_\_\_\_  
City, State, and Zip Code

to release and/or disclose the medical

Release and/or disclose records and information regarding:

\_\_\_\_\_  
Name of Patient (List Other Names Used)

\_\_\_\_\_  
Medical Record Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_ (enter date) or for one year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDIS- I understand that the requester may not lawfully further use or disclose the health  
CLOSURE: information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

SPECIFY Check the box and initial which type of information is to be released and/or disclosed

RECORDS  General Medical Information (from \_\_\_\_\_ to \_\_\_\_\_)

TO BE  Information Regarding Specific Injury or Treatment (from \_\_\_\_\_ to \_\_\_\_\_)

RELEASED  X-Ray (check one or both):  Films  Reports

AND/OR  Laboratory Results

DISCLOSED:  Mental Health (from \_\_\_\_\_ to \_\_\_\_\_)

\_\_\_\_\_  
Signature of Patient's Representative

Alcohol/Drug (from \_\_\_\_\_ to \_\_\_\_\_)

\_\_\_\_\_  
Signature of Patient's Representative

\_\_\_\_\_  
Date

HIV Test Results (from \_\_\_\_\_ to \_\_\_\_\_)

\_\_\_\_\_  
Signature of Patient's Representative

\_\_\_\_\_  
Date

Other (specify): \_\_\_\_\_

I request that the health information released and / or disclosed pursuant to this authorization be used for the following Purposes only: \_\_\_\_\_

A copy of this authorization is valid as an original.

I have the right to receive a copy of this authorization. The copy is for me to keep.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Indicate Relationship (if signed by other than Patient)