California HIPAA Authorization Form

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Please complete **all sections** of this HIPAA Authorization Form. If any sections are left blank, this form will be invalid. Use N/A if not applicable.

Section 1 – Patient/Plan Member Information

Last Name: _____

First Name: _____ Middle Name: _____

Reference Nº: _____ Date of Birth: _____

Address: _____

City/State/ZIP: _____

Section 2 - Individual/Organization Authorized by Signatory to Disclose PHI

Name: Dean Ezaki, OD

Address: 776 W. Napa St

City/State/ZIP: Sonoma, CA 95476

Section 3 - Individual/Organization Authorized by Signatory to Receive PHI

Name: _____

Relationship to Patient/Plan Member: _____

Telephone Nº: _____

Address: _____

City/State/ZIP: _____

Section 4 - Authorization Expiration Event or Date

Unless otherwise revoked by the patient/plan member, this authorization for the release of PHI to the above-named individual/organization will expire on the event or date specified below. Enter N/A in both fields if the release is ongoing.

Expiration Event: _____ Expiration Date: _____