THOMAS L. HOROWITZ, D.O.
BOARD CERTIFIED
FAMILY MEDICINE
1300 North Vermont Avenue, Suite 610
LOS ANGELES, CA 90027
TELEPHONE (323) 666-5550
FAX (323) 666-5552

RELEASE OF MEDICAL RECORDS TO DR. HOROWITZ

Patient Information:

Patient last name _____ Patient first name: _____ Date of birth _____

Patient former name (if ay) _____ Patient address _____

Patient email _____ Home phone _____ cell _____ wk _____

Recipient Information:

I, _____, do hereby authorize _____ to release a copy of my medical record to the person or facility below. Name and address of person to receive medical record:

Thomas Horowitz, D.O, 1300 North Vermont Avenue, Suite 610, Los Angeles, CA 90027

Information to be Released:

□ Visit notes □ EKG/echo □ Immunizations □ Lab reports □ Mammograms □ Pathology reports □ Stress tests □ x-ray reports

□ Other (Be specific) _____ □ Entire medical record

Purpose of Information Release:

□ Further medical care □ Payment of insurance claim □ Legal investigation □ Applying for insurance □ vocational rehab evaluation □ Disability determination □ At the request of the individual □ Other (specify) _____

Inclusion of Privileged Information:

I understand that if my record contains information concerning alcohol or drug abuse/treatment that is protected by Federal Regulations 42 CFR, Part 2, or information concerning abortion, HIV testing and related information. AIDS or AIDS-related condition, genetic testing, STDs, domestic/sexual abuse, or developmental disabilities that is protected by MGL c111 70, such information will be included in this disclosure.

If you do not wish to have released any of the categories of information described above, please specify:

_____

Patient Rights and Privacy:

I understand that I do not have to sign the authorization in order to receive treatment or payment or to enroll or be eligible for benefits. I understand that I may revoke this authorization by providing a written statement to Dr. Horowitz except to the extent that my records have already been released. I understand that protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient(s) to other individuals or organizations that are not subject to privacy protection laws. I also hereby release Dr. Horowitz from al legal responsibilities and liabilities that may arise from the release of such protected health information. I understand that this authorization is valid for the disclosure of the specified protected health information to the recipient above for a period of six months, and it automatically expires six months after the date this form is executed.

Signature of Patient or Personal Representative: _____ Date _____

If signed by a personal representative, state your relationship to patient and/or reason and legal authority for signing:

Patient is: □ minor □ incompetent □ disabled □ deceased

Legal authority: □ parent □ legal guardian □ next of kin of deceased

For In-Office Use Only:

Date received _____ ID Provided (specify) _____ Date released _____
Sent by □ fax □ mail □ picked up in person by _____