Minimally Invasive Surgeons of North County
2385 S. Melrose Drive
Vista, CA 92081
Office: 760-300-3647
Fax: 760-432-1316

Adam Fierer, M.D. FACS Karen Hanna, M.D. FACS Jay R. Grove, M.D. FACS

AUTHORIZATION TO RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, Date of birth: _____
Patient/client name

authorize _____
Name of person or facility, which has information

to release protected health information to:

Minimally Invasive Surgeons of North County
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Vista, CA 92081
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TYPE OF RECORD

☐Medical ☐Billing ☐Radiology Images

INFORMATION TO BE RELEASED

☐Inpatient written/electronic records (Discharge summary, History & Physical, Progress notes, operative reports, consultation, laboratory, radiology, medication and other diagnostic reports)
☐Outpatient written/electronic records (Office notes, consultations, operative reports, laboratory, radiology, medication and other diagnostic reports)
☐Immunization Records
☐Emergency Department Reports
☐Other: _____

_____

SPECIFY THE APPROXIMATE DATES OF TREATMENT FOR INFORMATION SELECTED:

_____

The purpose of this release is (check all that applies)

☐Continuing medical care ☐Insurance ☐Legal matter
☐Other: _____

NOTICE

MISNC and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep confidential, it may no longer be protected by state of federal confidentially laws.

My Rights

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned by signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party.

- I may revoke this authorization at any time, provided that I do so in writing and submit it to: Minimally Invasive Surgeons of North County
  2385 S. Melrose Drive
  Vista, CA 92081

- I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

- I am entitled to receive a copy of this Authorization.

Expiration of Authorization

Unless otherwise revoked, this Authorization expires on the following date, event or condition: _____
(Insert applicable date)

If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed.

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

_____ Date: _____
(Signature of Patient or Patient's Legal Representative)

_____
(Printed name)

_____
Relationship to patient (if other than patient)

_____ Date: _____
Signature of Provider validating identification