Mobile Copy Service HIPAA Compliant Authorization to Release Confidential Information

Patient Name:	Date of Birth:	Social Security Number:
Medical Record Number:	Date(s) of Accident/Treatment:	

I, the undersigned, request that health information regarding my care and treatment be released as set forth on this form. I authorize the following facility to release this information to **Mobile Copy Service** or it's representatives, on behalf of the following company/requester:

Facility Name: Harbor UCLA Medical Center
Facility Address: 1000 West Carson Street Torrance, CA 90502

I, the undersigned, request that the facility listed above release the following health information:

Release The Following: *(indicate by checking appropriate box below)*

☐ Medical Records, Billings and X-rays from *(insert date)* _____ to *(insert date)* _____.

☒ Any and All Medical Records, Billings and X-rays

☐ Other: *(be specific)* _____

Include Records Pertaining To: *(if applicable, indicate by initialing below)*

_____ Alcohol/Drug Treatment, Testing, Infection, Evaluation & Treatment Information.
_____ Mental Health, Psychiatric, Psychological Testing, Evaluation, & Treatment Information.
_____ HIV/AIDS Testing, Infection, Evaluation & Treatment Information.

I, the undersigned, understand that this information will be used for the sole-purpose of aiding the Attorney/Insurance Company in determining the nature and extent of injuries, damage, wages/earnings lost, and for the establishment of liability of claim for benefits & compensation. Also, it is understood that this authorization does not condition any treatment and/or payment. I, the undersigned, understand that the information may be disclosed to the Facilities' representatives, and that once the requested information is disclosed to the requesting party, it may be re-disclosed by the recipient and may no longer be protected by State or Federal Law. Mobile Copy Service will not re-disclose any information regarding the patient other than to the party listed below and/or any of its representatives.

Attorney/Insurance Company:
Case/Claim Number:

I, the undersigned, have the right to revoke this authorization at any time notifying, in writing, the facility at the address above, and Mobile Copy Service at 325 Maple Ave Torrance, CA 90503. I may revoke this authorization in writing at any time, except to the extent that the facility has already replied to the authorization by releasing the requested records. Also, I have read and received a copy of this authorization and acknowledge that a photocopy of this form shall be as valid as the original.

This authorization shall remain in effect for a maximum of one (1) year unless a different expiration date is indicated here: _____ *(indicate expiration date).*

✘ _____ ✘ _____

Signature of Patient/Guardian/Personal Representative Today's Date

If NOT signed by the patient, print signer's name: _____

If NOT signed by the patient, indicate legal relationship to patient: _____