Fortanasce & Associates Neurology Center
665 W. Naomi Avenue, Suite 201
Arcadia, California 91007
Bus: (626) 445-8481
Fax: (626) 574-9669
www.HealthyBrainMD.com

Privacy and Confidentiality in California

California law prohibits the disclosure records that contain a patient's medical information by any person or entity without first obtaining a valid authorization for release of the information. The law also gives patients the right to cancel or revoke their authorization at any time. Authorizations are not required for the release of medical information when compelled by a court order, by a search warrant, or if otherwise required by law.

To Request a Copy of Your Medical Records:

(1) Complete the attached form **"Authorization to Use and Disclose Protected Health Information."**
   A. **Section 1 Demographic Information:** please enter the following: patient name, date of birth, address, phone and last 4 digits of social security number.
   B. **Section 2 and 3** is asking you, "How would like your request to be handled?" **Please be advised that in order to process your request, a valid Photo ID with signature, must be included with your authorization form.** If you want someone to pick up your records on your behalf, please include the name of your *Representative* in the space provided. **Please instruct your *Representative* that they must present a valid Photo I.D. matching the name listed in this section to obtain your records.** If you want the information to be faxed, please provide the fax number. If any of the information is being faxed or sent to someone other than yourself; provide the name and address of the person who will receive your information.
   C. **Section 4** wants to know, "How long is this authorization valid?" If you do not list a specific date in the space provided, the authorization will be valid for a period of 90 days from the date of your signature. **This Section requires that you provide your initials in the space provided.**
   D. **Section 5** outlines your *Individual Rights* as they pertain to this authorization form.
   E. **Signature/Date/Time:** In order to process your request, this section must be completed.

(2) **Cost For Processing:** A fee of $25.00 will be assessed for providing a copy of your protected health information records. If you have questions related to the cost of obtaining your records, please call (626) 445-8481.

(3) Upon receipt of your "Authorization" and at our office, we will provide the information requested in 5 working days. Should your physician require the information at an earlier date, please have your physician's office contact our office directly.

(4) Submit the completed authorization form in person, by fax or mail to the following address.

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby authorize the Fortanasce & Associates Neurology Center to use or disclose my medical record as follows:

Patient Name: ____________________________

Date of Birth: _____________________________

Address (Street, City/State, Zip): ____

Telephone/Mobile: ________________________

SSN (last 4 digits): _________________________

2. Purpose of the requested use or disclosure (information will be used for):

☐ Patient/Representative Use **or** ☐ Other (please specify) _______________________

3. I am requesting that the records identified above be handled in the following manner:

☐ Mail To Address Listed Above

☐ I will pick-up;

☐ Fax Number/Attn: __________________________

☐ A *Representative* will pick-up on my behalf (name of *Representative*): ______________

Mail information to: ☐ Clinic ☐ Dr. Office ☐ Hospital ☐ Attorney ☐ Other

Name/Address/Phone: ____

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Upon receipt of your "Authorization" in the medical offices of the Fortanasce & Associates Neurology Center, we will provide the information requested in 5 working days. Should your physician require the information at an earlier date, please have your physician contact one of our physicians directly.

4. Unless otherwise revoked, or an alternative expiration date is provided here _____________________ this authorization is valid for ninety days (90). Initials: ________

5. Individual Rights:

A. I may refuse to sign this Authorization;

B. I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to:

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C. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization;

D. I have a right to receive a copy of this authorization.

E. I may inspect or obtain a copy of the health information that I am being asked to use or disclose;

F. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on me signing this authorization.

____ __________
Patient Signature/Patient Representative Date

____
(Relationship If Signed by other than Patient)

(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.)