HIPPA COMPLIANT RELEASE OF MEDICAL INFORMATION

I,_____(your full name), born on _____ (date of birth) authorize **Alex R. del Rosario, MD** custodian of my medical records to release a CD-ROM of my entire medical information to:

Physician Name:	
Address Line 1:	
Address Line 2:	
City, State , ZIP:	
Telephone:	

---------- OR ----------

[✔] Send a CD-ROM of my medical records to myself at the below indicated address:

Address:_____

City_____ ST_____ Zip_____

I understand the information to be disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), psychological or psychiatric treatment, behavioral or mental health services, genetic testing, sickle cell testing, and alcohol and drug abuse.

I understand the following:

(1)I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
(2)My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
(3)This authorization shall survive and not terminate upon my mental incapacity or legal disability.
(4)This authorization will expire 1 year from the date signed below.
(5)A digitally scanned copy of this Authorization shall be treated in the same manner as the original.

X_____ _____
Patient Signature Date Signed

_____ _____
Patient's Name Printed Telephone #

Send this completed form, and a check for $4 made out to Alex del Rosario, MD and mail to:
Alex del Rosario, MD, P.O. Box 69362, West Hollywood, CA 90069