Precision Occupational Medical Group, INC.
Authorization of Use or Disclosure of Health Information.

The completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth below consistent with California and Federal law concerning the Privacy of such information. Failure to provide all information requested may invalidate this authorization. Your request will be processed and fulfilled within 4-7 business days from the day it is received.

Fees: $20.00 – records (copy)
$15.00 – per sheet of film

Patient Name: _____ Date of Birth: _____
Address: _____ Telephone: _____
_____ _____

I, _____, hereby authorize Precision Occupational Medical Group, INC. to the use and/or disclosure of my health information as follows:
Person/Organizations authorized to use and/or disclose the information: _____

Address of person/organization to receive the information: _____

This authorization applies to the following information:
____ Entire record ____ These specific dates only: _____
____ EMG/NCV Report Dates: _____

Purpose of use or disclosure of information:
____ To comply with court order ____ Required for insurance claim ____ Application for insurance
____ For personal use ____ Payment of a bill ____ Other _____
____ For follow-up care ____ To update medical records _____

Expiration: _____(This authorization expires-insert date/event)

Restrictions: California law prohibits the requestor from making further disclosures of my health information, unless the requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law.
Patients Rights:

- I further understand that I have a right to receive a copy of the authorization upon my request
  Copy requested and received ☐YES ☐NO _____ INITIAL
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to the following address: _____
- 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.
- I have right to receive a copy of this authorization.

SIGNATURE:

Date: _____ Time: _____ AM/PM

Signature: _____
(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient state your legal relationship to the patient:

Witness: _____

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