Andrew B. Newman, M.D., F.C.C.P
Respiratory Medicine * Undersea Medicine * Sports Medicine
3351 El Camino Real Suite 200
Atherton, California 94027-3802
Phone: 650.328.5222 Fax: 650.324.4374
andrew@newmanmd.org

Authorization for Release of Protected Health Information **This authorization complies with the HIPAA Privacy Rule**

Patient Information:

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Telephone #: _____

City: _____ State: _____ Zip: _____ Last 4 Digits of SSN#: _____

Personal Email Address:

_____

(Please write clearly and double check for accuracy. Failing email addresses will default to U.S. Mail)

Recipient Information:

Please choose the method of delivery by checking the box that applies and filling in the information required. Be certain that information is accurate and complete. Incomplete authorizations are invalid.

☐ Please email me the records.
(Records will be sent to the email address listed above)
(Email recommended for fastest delivery of records)

☐ U.S. Mail: Attn: _____

_____

☐ I prefer to pick my records up personally.
Please call me when they are ready.
(Photo ID will be required for pick up)

☐ U.S. Mail: To my personal address.
(Records will be mailed to address listed above) _____ _____
Phone # Fax #

Information to be Released:

Below, please detail the amount or specific type of health information to be released.

☐ Abstract (pertinent health summary) ☐ Entire Chart ☐ Specific Records (see below)

Only check the boxes below if you are requesting specific records to be released. (*Check all that apply*)
☐ Progress Notes ☐ Labs ☐ X-Rays ☐ Other

_____

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For the following dates of treatment:

_____

(For example: specific date 6/29/07 or a range of dates July 2005 to Present)

Purpose for Disclosure:

The reason I am requesting this information to be released is:

Protected Health Information:

If your record contains any of the following sensitive information, you must specify that you **DO** want it released. Check the boxes below and initial the line next to the information you want released.

☐ HIV/AIDS____ ☐ Mental Illness ____ ☐ Drug/Alcohol Abuse ____ ☐ Genetic Testing ____

Legal Notices:

- ✓ I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization.
- ✓ I am entitled to a copy of this authorization upon my request.
- ✓ I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits.
- ✓ The recipient of this protected health information is prohibited from redisclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law.
- ✓ Where permitted, the information I am requesting to be disclosed may sometimes be redisclosed by the recipient and may no longer be protected by law.
- ✓ I understand that this authorization will expire in 90 days from the date of my signature.

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Signature of Release:

I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

_____
Signature of Patient Date

_____
Signature of Parent/Guardian or Personal Representative Date

_____
Signature of Witness (Mental Health releases must be witnessed)