HIPAA Compliant Authorization for the Release of Medical Information to JMC Medical

Patient Name_______________________________________ Date__________________________________

Date of Birth_______________________________________ SS#___________________________________

I authorize and request the disclosure of all protected information to **JMC Medical** for the purpose of medical care and/or review. I expressly request that the designated record custodian of all covered entities under HIPAA identified below disclose full and complete protected medical information.

____
Name of Healthcare Provider/physician/facility/medicare contractor

____
Street Address

____ ____________________ _______________________
City, State and Zip Code Office Number Fax Number

Specify records to be released and/or disclosed:

- ☐ All records, reports, diagnostic studies and lab reports
- ☐ **Most recent** office visit note, labs and diagnostic studies including but not limited to echocardiogram, coronary angiogram, right heart catheterization, stress test, vascular studies, MRI, CT…
- ☐ Other (please specify): ____

This protected health information is disclosed for the following purposes:_________________________________

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Jorge M. Castellanos M.D. | Vinod Kannarkat M.D.
2001 Westcliff Drive, Suite 301 · Newport Beach, CA 92660 · Telephone 949-881-7883 · Facsimile 1-888-498-4633

I hereby authorize all of my medical history and records to be released to JMC Medical to the address below by facsimile, mail or email:

JMC Medical

2001 Westcliff Dr, Suite 301

Newport Beach, CA 92660

Main: (949) 881-7883

Fax: (888) 498-4633

info@jmcmedicalgroup.com

Any facsimile, copy or photocopy of this authorization shall authorize the release of the records requested herein. This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance of this authorization before the written revocation was received. There is no expiration date for this authorization.

______________________________________ ________________________________

Patient signature Date

______________________________________ ________________________________

Patient representative Relationship

❑ Parent or guardian of a minor patient ❑ Guardian or conservator of an incompetent patient