ONE CALL MEDICAL, INC.
HIPAA COMPLIANT AUTHORIZATION
FOR THE RELEASE OF MEDICAL RECORDS

(THIS AUTHORIZATION MUST BE FULLY COMPLETED, SIGNED AND DATED)

TO: One Call Medical, Inc.

ADDRESS: P.O. Box 614
20 Waterview Blvd.
Parsippany, NJ 07054
Attn: Medical Records Management Department

RE: Patient Name: ______________________

Date of Birth: __________ Social Security Number: ____ ____ ____

Address: ______________________
____

Date(s) of Health Care Service(s): ______________________

Section 1

I authorize the disclosure of all protected health information and I expressly request that the designated records custodian of One Call Medical, Inc. disclose full and complete protected health information including the following: **[Provide description of information to be used or disclosed that identifies the information in a specific and meaningful fashion in the space provided below.]**

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Section 2

This protected health information is disclosed for the following purposes:

- ☐ This disclosure is made at my request in compliance with 45 CFR 164.508(c)(1)(iv).
- ☐ This disclosure is made at my request in compliance with 45 CFR 164.528(a)(1) (accounting of disclosures)
- ☐ My lawsuit filed in [court] ______________________
- ☐ Other (describe) ______________________

Section 3 (if applicable)

You are authorized to release the above records to the following representatives of   in the above entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

Name of Representative	Representative Capacity (e.g. parent or guardian)
Address	

This authorization does not apply to psychotherapy notes.

I acknowledge that I have the right to revoke this authorization, in writing, by sending written notification to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under HIPAA privacy rules.

I understand that One Call Medical, Inc. may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization, unless a condition set forth at 45 CFR 164.508(b)(4) applies.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

Section 4

This authorization shall be in force and effect until:

- ☐ Date:______________________________
- ☐ Event (describe):________________________

Section 5

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Signature of Patient or Personal Representative (i.e., parent, legal guardian, executor)

____

Dated

____

Name of Patient or Personal Representative (i.e., parent, legal guardian, executor)

____

Description of Personal Representative's Authority to

Sign for Patient (attach documents which show authority)