Patient Directive for the Disclosure of Health, Employment, and Legal Records
(Compliant with HIPAA and State Laws)

I authorize _____
Patient Directive authorizing the disclosure of Protected Health Information (PHI)

The undersigned patient, or the patient's personal or legal representative, hereby requests and directs the release of the information described below to a representative of Lopez & Associates, Inc., as authorized by the patient, the patient's representative, or the patient's attorney.
This authorization conforms to California Civil Code Section 56.11; 45 CFR § 164.508 and § 164.512; and other applicable federal regulations, including the HIPAA Final Rule to Support Reproductive Health Care Privacy (2024), California Welfare and Institutions Code Sections 5328, and 42 CFR § 2.31.

Patient/Employee: _____
AKA: _____
Date of Birth: _____ Social Security No: _____

For the purpose of: Assisting the patient, the patient's attorney, claims examiner, or defense counsel in determining the nature and extent of a claim related to injuries or disabilities, and to establish liability for benefits, expenses, compensation, or damages.
Scope of Information: This authorization applies to the following types and amounts of information unless otherwise specified by type and date:

- **Any and all information in digital format when available (original format);**
- **or Specific types of information and dates as described below.**

☐ Any and All Medical Records ☐ from _____ to _____
☐ Itemized Patient Billing ☐ from _____ to _____
☐ Radiology Reports Only ☐ from _____ to _____
☐ Radiology Images (digital format) ☐ from _____ to _____
☐ Consultative Reports
☐ Laboratory/Pathology Reports
☐ Personnel/Employment ☐ Wage/Earnings
☐ Genetic Testing (as governed by 45 CFR § 164.502 and § 164.512)
☐ Other:_____

This authorization conforms to California Civil Code Section 56.11; 45 CFR § 164.508 and § 164.512; applicable provisions of the Federal Register (Dec. 28, 2000, pg. 82811); California Welfare and Institutions Code Sections 5328; 42 CFR § 2.31; and all Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR § 164 requirements, including the Final Rule to Support Reproductive Health Care Privacy (2024).

DISCLOSURE REQUIRING SPECIAL CONSENT

My signature below specifically authorizes the release of healthcare information related to the testing, diagnosis, or treatment of the following: (Please initial the applicable areas)

- **HIV/AIDS virus: _____**
- **Mental Health/Psychiatric Disorders: _____**
- **Sexually Transmitted Diseases (STDs): _____**
- **Drug or Alcohol Abuse/Treatment: _____**
- **Genetic Testing (as governed by 45 CFR § 164.502 and § 164.512): _____**

Right to Revoke:

I understand that I may revoke this authorization at any time by submitting a written request to the Health Information Management Department. However, I acknowledge that this revocation will not affect any information already disclosed in reliance on this authorization. Furthermore, the revocation will not apply to my insurance company if the law permits my insurer to contest a claim under my policy.

This authorization includes protections under the HIPAA Final Rule to Support Reproductive Health Care Privacy (2024), ensuring that protected health information (PHI) related to reproductive health care is not used for prohibited purposes, such as imposing liability for lawful reproductive health care.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If no specific expiration or event is provided, this authorization shall remain **valid for one year** from the date signed.

Neither treatment, payment, enrollment, nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I understand that I have the right to inspect or obtain a copy of the information authorized for use or disclosure, as outlined in **45 CFR § 164.524**. I acknowledge that disclosed information may be subject to unauthorized re-disclosure by the recipient and may no longer be protected under federal confidentiality rules. If I have any questions regarding the disclosure of my health information, I may contact the Director of Health Information. I also understand that I have the right to receive a copy of this authorization.

_____ _____

Date ***(Signature of Patient, Parent, or Legal Guardian)***

_____ _____

Date ***(If signed by other than patient, indicate relationship & print name)***

This authorization conforms to California Civil Code Section 56.11; 45 CFR § 164.508 and § 164.512; applicable provisions of the Federal Register (Dec. 28, 2000, pg. 82811); California Welfare and Institutions Code Sections 5328; 42 CFR § 2.31; and all Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR § 164 requirements, including the Final Rule to Support Reproductive Health Care Privacy (2024).