PROMISECARE
Quality Healthcare. Promised.

Hemchand Kolli, M.D.
36243 Inland Valley Drive, Suite 160 Wildomar, CA 92595
(951) 698-8821
https://drkolli.health/

Authorization for the Use or Disclosure of Protected Health Information

I, _____, hereby authorize the usage or disclosure of Protected Health Information from the health records of the patient listed below (Please print clearly):

Patient Name:	SSN:
Phone Number:	Date of Birth:
Release Information to: Hemchand Kolli, M.D.	Receive Information From:
Person/Organization:	Person/Organization:
Address: 36243 Inland Valley Drive, Suite 160 Wildomar, CA 92595	Address:
Phone Number: (951) 698-8821	Phone Number:

Purpose of Disclosure:

☐ Personal Access

☐ Other (Describe: _____)

☐ Continued Care

A separate authorization is required to authorize the disclosure or use of psychotherapy notes and HIV test results.

The type of records and the dates of service to be released or disclosed is as follows. Check all that apply:

☐ Entire record (including Alcohol/drug treatment information)

☐ Entire record (excluding Alcohol/drug treatment information)

☐ Billing information

☐ Medication list

☐ Laboratory results

☐ Mental health records excluding other diagnostic (specify: _____)

☐ Problem list

☐ Immunization records

☐ X-ray reports

☐ Psychotherapy Notes

Date(s) of service:_____

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I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Authorization Expiration

Authorization will automatically expire six months from the date of execution unless otherwise noted.

Your Rights

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information to be used or disclosed, as provided by 45CFR 164.508 (d) (1), (E) (2). I have a right to receive a copy of this authorization. I may revoke the authorization at any time but must do so in writing and submit it to: Hemet Community Medical Group/affiliates, Member Services Department, 41885 E. Florida Ave., Hemet, CA 92544. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I understand that information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). The recipient of this information is requested not to re- disclose this information without my authorization for disclosure. Hemchand Kolli, M.D., its employees, officers, and physicians are hereby released from any legal responsibility or liability for improper re-disclosure of the above information to the extent indicated and authorized herein.

A copy or photocopy of this authorization will serve the same validity as though an original had been presented.

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BY: _____ _____ _____

Patient or Representative | Date | Relationship

Printed Name/Signature

BY: _____ _____

Signature of Witness | Date

Printed Name/Signature

Office Use Only

Authorization received by: _____

Date: _____

Patient/Representation identification: _____

Verified by: _____

A copy of this authorization was offered/received by the patient: Y/N

Chart location: _____