SCHWARZBEIN
INSTITUTE

Request and Authorization for Release of Health Information ("Authorization")

Patient's Name: _____

Pt/Med Records # _____ **D.O.B.** _____ **Last 4/SSN** _____

Patient's Address: _____

_____

Name and Address of Healthcare Provider or Institution ("You"):

_____

_____

Attn: _____

Request and Authorization

You are hereby requested and authorized to release to Diana Schwarzbein, MD, d/b/a The Schwarzbein Institute, copies of the below described health records as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations.

Treatment Dates to Which this Authorization Relates: _____

Health Records to Which this Authorization Relates:

- ❑ Laboratory Results
- ❑ Other Diagnostic test Results
- ❑ Operative Reports
- ❑ Other: _____

  _____

I understand you may charge a reasonable fee for copying the records, but will not charge for time spent locating the records.

I look forward to your sending the above records within 30 days of the date hereof, as specified under HIPAA. If my request cannot be fulfilled within 30 days of the date hereof, please so inform me by letter and state the date I might expect to receive my records.

The above requested Health Records may be provided to Dr. Schwarzbein, as follows:

- ❑ By USPS first class mail to 350 South Hope Avenue, Suite A-102, Santa Barbara, CA 93105
- ❑ By fax to 805.563.0095
- ❑ By email to m.a@schwarzbeinprinciple.com

_____ _____

Patient's Signature Date