Valerius Medical Group
Advanced, patient-focused care for inflammatory & autoimmune disorders

Authorization of Disclosure of Protected Health Information by Another Covered Entity for Use by Valerius Medical Group & Research Center

Persons Authorized to Disclose Information
Name of person/organization

_____

_____

_____

Information to be obtained under this authorization includes:

☐ History & physical, progress notes, consultations; laboratory, imaging, and/or diagnostic studies
☐ Laboratory Studies _____

☐ Imaging/diagnostic Studies: _____
☐ Hospitalization (history & physical, consultations, laboratory, imaging and/or other diagnostic studies. Approximate date(s) of hospitalization: _____

☐ Other: _____

Information described above may be disclosed to:

_____
Valerius Medical Group & Research Center
10861 Cherry Street, Suite 104
Los Alamitos, CA 90720

Telephone: (562) – 794-9801 Facsimile: (562) – 685-0570

Expiration Date of Authorization
This authorization is effective through ____/____/____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Valerius Medical Group. You should contact the privacy officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which/from which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Valerius Medical Group discloses it to another party.

Rights of the Individual
❖ You may inspect or request a copy of information that is used or disclosed under this authorization. ❖ You may refuse to sign this authorization.

Name of Patient (Print or Type): _____ Date of Birth: _____

Address: _____

Signature of Patient: _____

Date: _____

Signature of Patient Representative: _____
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient: _____