FORM 13.D.1

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION(PHI)

All Sections must be completed. Use "N/A" if not applicable		
I. PATIENT INFORMATION		
Last Name:	First Name:	MI:
Date of Birth:	Phone:	Email:
Address:	City/State/Zip:	
II. INDIVIDUAL/ORGANIZATION AUTHORIZED TO RELEASE PHI		
[Enter full name and address of the clinic or facility where treatment was rendered]		
MedAmerica Billing Services, Inc. (MBSI) d/b/a Vituity 1601 Cummins Drive, Suite D Modesto, CA 95358 (209) 567-5755		
III. INDIVIDUAL/ORGANIZATION TO RECEIVE PHI		
The undersigned authorizes release of information pursuant to this Authorization to:		
Name:	Phone:	
Address:	City/State/Zip:	
IV. HEALTH CARE RECORDS TO BE RELEASED		
I authorize the records (as specified below) for the following period to be released:		
From (mm/dd/yyyy):	To (mm/dd/yyyy):	
Facility or Hospital Where Treated (if applicable):		
☐ Billing Records	☐ Medical Records	Please note MBSI houses billing records ONLY.
Form of Release	☐ Electronic	☐ Hard Copy
The following information requires the initials of the patient/patient's representative to allow release:		

	Initial		Initial
☐ Communicable Disease		☐ Genetic Testing Records	
☐ Medication Assisted Treatment		☐ Mental Health Records	
☐ Substance Use Disorder Records		☐ HIV Test Results	

V. PURPOSE FOR THE RELEASE OR USE OF INFORMATION			
☐ Health Care	☐ Personal Use	☐ Legal	☐ Other (specify):

VI. EXPIRATION DATE OR EVENT

If no expiration date or event is identified, then this Authorization expires twelve (12) months after the date it is signed unless otherwise revoked by the patient/personal representative.

Expiration Date:	Event:

VII. AUTHORIZATION INFORMATION

I understand the following:

1. I authorize the use or disclosure of my individually identifiable protected health information as described above for the purpose(s) listed. I understand this authorization is voluntary.
2. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure.
3. I have the right to revoke this authorization, but I must submit my request in writing to the individual or entity identified in Section II above. My revocation will take effect upon receipt, except to the extent others have acted in reliance upon this Authorization.
4. I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. However, if I refuse to sign this authorization, I may be refused care if it is being provided solely for the purpose of collecting health information to be released to a third party (for example, pre-employment exams or occupational health exams).
5. I understand that the information released by this authorization may be redisclosed by the recipient and no longer protected by federal privacy regulations; however, California law prohibits the recipient from making further disclosure of the information unless written authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
6. I have a right to receive a copy of the authorization.
7. Reasonable fees may be charged to cover the cost of copying and postage related to release this protected health information.

VIII. PATIENT/PERSONAL REPRESENTATIVE SIGNATURE	
Patient Name:	
Signature:	Date:
Name of Person Signing if Not Patient:	
Signature:	Date:
Describe Authority to Sign on Behalf of Patient:	
WITNESS SIGNATURE: A signature of a witness who can attest to the identity of the authorized signatory is required to release any mental health or developmental disabilities information or to revoke any previous authorizations, regardless of the patient's age. The witness cannot be the same person as the authorized signatory. (IL only)	
Witness Name:	
Witness Signature:	Date: