

Custodian of Records: Pursuant to AB 1337, effective January 1, 2016, **all** medical providers are now required to accept this signed and completed authorization form in California for the disclosure of health information. (See <https://leginfo.legislature.ca.gov/> for full text of the bill.)

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION
PURSUANT TO EVIDENCE CODE SECTION 1158

The undersigned authorizes the medical provider designated below to disclose specified medical records to a designated recipient. The medical provider shall not condition treatment, payment, enrollment, or eligibility for benefits on the submission of this authorization.

The disclosure of records authorized herein is required for the administration of a claim.

Medical provider: _____

Patient name: _____

Medical record number: _____

Date of birth: _____

Address: _____

Telephone number: _____ Email: _____

Recipient name: Lexitas

Recipient address: PO Box 3010 Rocklin, CA 95677

Recipient telephone number: 800-497-7618

Health information requested (check all that apply):

- Records dated from _____ to _____.
- Radiology records: _____ images or films _____ reports _____ digital/CD, if available.
- Laboratory results dated.
- Laboratory results regarding specific test(s) only (specify) _____.
- All records.
- Records related to a specific injury, treatment, or other purpose (specify): _____.
- Any and all Pharmacy records

Purpose: For Administration of Claim.

Note: records may include information related to mental health, alcohol or drug use, and HIV or AIDS. However, treatment records from mental health and alcohol or drug departments and results of HIV tests will not be disclosed unless specifically requested (check all that apply):

- Mental health records.
- Alcohol or drug records.

HIV test results.

Method of delivery of requested records:

Mail

Pick up

Electronic delivery: incomingrecords@castlecopy.com

This authorization is effective for one year from the date of the signature unless a different date is specified here: _____.

This authorization may be revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request.

A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization.

Notice: Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I certify that this medical release authorization was printed in 14-point type when I signed it. I have received a copy of this authorization.

Patient signature*: _____

Date: _____

Print name: _____

*If not signed by the patient, please indicate relationship to the patient (check one, if applicable):

Parent or guardian of minor patient who could not have consented to health care.

Guardian or conservator of an incompetent patient.

Beneficiary or personal representative of deceased patient.