HIPAA Authorization Form

Name: Lindon Claires

Address: 16 Vicenza St

City, State, ZIP Code Long Beach, CA 90801

Email address: lindon.claires@yahoo.com

Phone number: (666) 1764-7869

Date: April 6, 2018

Recipient's name: Dr. Karlo Hurst, MD

Recipient's address: 18 Crane Avenue

City, State, ZIP Code: Long Beach, CA 90801

Dear Dr. Karlo Hurst, MD,

I, Lindon Claires hereby authorize the release of my protected health information (PHI) as described below, pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

1. **Patient Information:**

Full Name: Lindon Claires

Date of Birth: May 6, 1953

Address: 16 Vicenza St

City, State, ZIP Code: Long Beach, CA 90801

Phone Number: (666) 1764-7869

Email Address: Long Beach, CA 90801

2. **Recipient Information:**

Full Name/Entity Name: St Marc's Hospital

Address: Madison Archway Avenue

City, State, ZIP Code: Long Beach, CA 90801

Phone Number: (178) 379-3849

Email Address: contact@stmarc.org

3. **Purpose of Disclosure:** I authorize the disclosure of my PHI for the purpose of seeking a second opinion regarding my medical condition

4. **Description of Information to Be Disclosed:** Including but not limited to, laboratory test results, radiology reports, progress notes, and surgical records.

5. **Persons Authorized to Make Disclosure:** Lindon Claires, Dr. Karlo Hurst, MD

6. **Persons Authorized to Receive Disclosure:** St Marc's Hospital

7. **Duration of Authorization:** April 6, 2018 - April 6 2019

8. **Right to Revoke Authorization:** I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken based on this authorization. Revocation of this authorization should be submitted in writing to the recipient listed in Section 2 of this form.

9. **Acknowledgment of Understanding:** I have read and understood the contents of this HIPAA Authorization Form, and I voluntarily sign it, knowing the purpose and consequences of authorizing the disclosure of my protected health information.

Patient's Signature: Linda Claires Date: April 6, 2018

Healthcare provider's Signature: _____ Date: April 6, 2018

Witnessed by: Louisa Claires Date: April 6, 2018

Witness's Signature:_____

10. **Consent for Electronic Signature:** By signing this form electronically or by any means of electronic communication, I acknowledge and agree that my electronic signature is legally binding and has the same force and effect as a traditional handwritten signature.

Patient's Signature: Lindon Claires Date: April 6, 2018