MEDICAL RECORDS RELEASE FORM

PATIENT IDENTIFICATION

Patient Full Legal Name: _____

Preferred Name: _____ Email Address: _____

Date of Birth: _____ Phone Number: _____

Address: _____

AUTHORIZATION FOR USE OR DISCLOSURE

By signing this document, I, the above-named, hereby grant permission to Prosilio Care for the use or disclosure of my health information as outlined below. I understand that this information may include records maintained by the healthcare provider concerning my physical or mental health or condition, treatment received, and billing records related to my healthcare.

TYPE OF AUTHORIZATION

Please **select one**:

☐ **Comprehensive Disclosure**: I authorize the disclosure of all my health-related information.

☐ **Partial Disclosure**: I authorize the disclosure of only the following health-related information:

[Please describe the specific health information you are authorizing for disclosure.]

☐ **Applicable Date Range**: Indicate the date range for which health information is relevant:

From: _____ To: _____

☐ **Other Disclosures:**

[Please specify any other health-related information not covered above.]

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AUTHORIZED RECIPIENT INFORMATION

I designate the following individual or entity to receive the health information specified:

Name of Authorized Party: Axiana

Relationship to Patient (if applicable): Medical Provider

Organization (if applicable): Axiana

Phone Number: (909)248-3248 Email Address: info@axiana.org

Address: 301 S Fair Oaks Ave Suite 105, Pasadena, CA 91105

I affirm that the Authorized Party named above is permitted to receive the health information as I have specified. This authorization does not permit further disclosure to additional parties unless specified and consented to by me in writing.

PURPOSE OF DISCLOSURE

The purpose for which I am authorizing disclosure:

☑ General healthcare operations ☐ Payment or billing ☐ Legal or insurance matters

☐ Other (Please specify): _____

EXPIRATION AND REVOCATION

This authorization shall remain valid until:

☐ A specific event occurs: _____

☑ Date: 6/30/2028

I understand that I have the right to revoke this authorization at any time by submitting written notice to, except where uses or disclosures have already been made based upon my original permission:

Name/Department: Axiana

Address: 301 S Fair Oaks Ave Suite 105, Pasadena, CA, 91105

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RIGHTS AND ACKNOWLEDGMENTS

I acknowledge that:

☐ I have read and understand my rights under HIPAA.

☐ I am aware that I may refuse to sign this authorization.

☐ I am entitled to receive a copy of this authorization.

☐ I may inspect or copy the authorized information.

☐ My refusal will not affect my ability to obtain treatment except in cases where the authorization is required by law.

SIGNATURES

_____ _____

Signature of Patient Date

_____

Print Name

If the patient is unable to sign, a legal representative may sign below:

Reason for patient's inability to sign: ☐ Patient is a minor ☐ Other (specify): _____

_____ _____

Signature of Legal Representative Date

_____

Print Name

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Legal Guardian

Other (Please specify): _____