Flexogenix, Inc
7422 Garvey Ave, Suite 203
Rosemead, CA 91770

RELEASE OF MEDICAL INFORMATION AUTHORIZATION FORM

For all record requests please send the form to one of the following:
Attn: Medical Records
Phone: (213) 572 - 6645
Fax: (213) 212 - 6710
Email: medicalrecords@flexogenix.com

I authorize Flexogenix Inc. to use or disclose to:

Name of Person or Facility:			
Address:	*City:*	*State:*	*Zip:*
Phone:	*Email address and/or Fax number:*		

The protected health information of:

Patient Name:			*Date of Birth:*
Address:	*City:*	*State:*	*Zip:*
Phone:	*Email address:*		

Dates of Service:

Put a CHECKMARK next to the specific documents that you request:

☐	Progress Notes (Clinic Notes)	☐	Treatment Prescription (Order)
☐	Consents for treatment	☐	Radiology Reports
☐	Procedure Notes	☐	Prescriptions (Radiology and/or medications)
☐	All Medical Records		
☐	Other (describe):		

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law, HIV/AIDS and other communicable diseases, and genetic testing. This authorization does not include permission to release psychotherapy notes (defined as records from private, joint, group, or family counseling sessions that are separated from the rest of the patient's medical record). Release of psychotherapy notes requires a separate authorization.

Put a CHECKMARK next to the specific documents that apply to your request:

☐	Attorney / Legal	☐	Social Services / Disability
☐	Personal Use	☐	Insurance
☐	Continued Patient Care	☐	Other:

Put a <u>CHECKMARK</u> next to how you would like to receive the records. This could be subject to change based on discretion of the office and/or staff:

□	Mail to address listed above	□	Pick up at office located at:
□	Receive password protected flash drive	□	Other:
□	Email to address listed above		

I UNDERSTAND THAT:

□ I may revoke this Authorization at any time:

- The revocation will not apply to information that has already been released in response to this Authorization
- I must revoke this Authorization in writing. The procedure for revoking this Authorization is to present my written revocation to the Medical Records Department

□ I may refuse to sign this Authorization:

- My treatment, payment, enrollment in a health plan, or eligibility for benefits can not be conditioned upon my authorization of this disclosure.

- A fee may be charged for providing the protected health information. Please contact our Medical Records Department at (213) 572- 6645

I have been informed and understand that information disclosed pursuant to the Authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.

Unless otherwise revoked, this authorization will expire on the following date: _____. If I fail to specify an expiration date or event or condition, this authorization will expire automatically in ninety (90) days from the date of signature

I have read and understand the information in this Authorization Form.

Signature of Patient or Authorized Representative:		
Printed Name:	*Date:*	*Time:*
Please explain Representative's authority to act on behalf of the Patient:		

Office Use Only

Processed Date:	□	ID has been checked
Processed By:		
Total Pages:		
Additional Notes:		