GRAND ROUNDS

Patient Authorization for Release of Medical Records for Continuity of Care

Name:	Elizabeth Parker
Address:	360 3rd Street, San Francisco CA 94107
Date of Birth:	1966-05-15
SSN:	xxx-xx-0021

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I hereby authorize the providers in Exhibit A to RELEASE and DISCLOSE my entire medical record, including but not limited to patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other healthcare providers, to Grand Rounds, Inc. my healthcare provider that requires these records to continue my care and provide me with treatment, review, or consultation.

I authorize the release of medical records containing any of the following checked items:

☑ Substance Abuse Information
☑ Psychiatric/Mental Health Information
☑ HIV/AIDS Information

I understand that my healthcare provider may not condition treatment or payment upon execution of this authorization. However, if I refuse to sign this authorization, then my healthcare provider may not be able to obtain my medical information. I understand that the information may be re-disclosed by the recipient and may no longer be protected by law. I hereby release my above listed healthcare provider and any of their HIPAA Business Associates involved in collecting my records from any legal liability that may arise out of the collection, gathering, scanning, digitizing, and release of the information requested. By signing below I express my intent to be bound by this authorization. I understand that I may revoke this authorization at any time except to the extent that action based on this authorization has been taken. Cancellation of this authorization must be made in writing and faxed to 877-351-5043.

This authorization expires one (1) year from the date it has been signed.

Signature: *Elizabeth Parker*

Email: mary+elizabethpwill@grnds.com

Date Signed: November 13, 2014

CONTACT OUR RECORDS DEPARTMENT: **1-800-929-0926**

FAX NUMBER: **1-888-323-5997**

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Exhibit A: Patient Authorization for Release of Medical Records for Continuity of Care

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PROVIDER NAME	ADDRESS
1. Dr. Greg Smith	300 Pasteur Drive, Palo Alto, CA 94305