FullyLiving Clinic
Asheena Lee M.D.

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888.628.3789
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AUTHORIZATION FOR RELEASE OF INFORMATION

Directions for Requesting Records: *Please complete all requested information in full. To protect your privacy and ensure secure delivery,* ***we do not send records via text or to personal phone numbers.*** *We provide records via Fax, Email, or U.S. Mail.*
Note on Paper Records: *Please be advised that medical files can often exceed 100 pages, which will impact your total cost.*

1. DELIVERY INSTRUCTIONS & FEES

In accordance with **California Health and Safety Code § 123110** and **HIPAA** regulations, the following fees apply and **must be paid in full** prior to the release of records:

- **Paper Records:** $0.25 per page, plus the actual cost of postage.
- **Electronic Records:** A flat rate fee of **$6.50** per request.

Select Delivery Method:
☐ Email Delivery (Standard Unencrypted Email) ☐ Paper Copy (U.S. Mail) ☐ FAX ☐ Other:

EMAIL DELIVERY DISCLAIMER: By selecting email delivery, I acknowledge that standard email is not a 100% secure method of communication. There is a risk that information may be intercepted by unauthorized third parties. I voluntarily accept this risk and authorize Fully Living Clinic to send my records to the email provided below.

2. PATIENT & RECIPIENT INFORMATION

I, ______________________________ (Name), DOB: _______________, hereby authorize **Fully Living Clinic / Asheena Lee M.D.** to release my health information to:

RECIPIENT / ORGANIZATION NAME ______________________________

PHONE NUMBER ______________________________

MAILING ADDRESS ______________________________

FAX NUMBER ______________________________

CITY, STATE, ZIP ______________________________

EMAIL ADDRESS (FOR RECORDS RELEASE) ______________________________

Information to release: ☐ All records (Max 7 yrs) ☐ Only: _______
Purpose: ☐ Care ☐ Transfer ☐ Personal ☐ Legal ☐ Other: _______________

This authorization is in effect until: ______________________________ (Date or event)

3. ACKNOWLEDGMENTS (INITIAL EACH)

Initial: _______ I understand this consent is voluntary and that I may revoke this authorization at any time by written, dated, and signed communication, except where uses or disclosures have already been made based upon my original permission.

Initial: _______ I also understand that my medical records may include mental health information, drug/alcohol information, and or HIV information.

Initial: _______ I understand that the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by by the HIPAA Privacy Standards.

Initial: _______ I understand I may refuse to sign this authorization. If I refuse to sign, the identified records

Initial: ________ I understand that the revocation will not apply to information that has already been released in response to this authorization.

PATIENT SIGNATURE	DATE SIGNED
PARENT / GUARDIAN SIGNATURE (IF REQUIRED)	RELATIONSHIP TO PATIENT