Amada Mendoza Nursing Corp
16660 Paramount Blvd Suite 306 Paramount CA 90723
Tel: (562)925-7716 Fax: (562) 867-0665 / (562) 5210669

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEDICAL INFORMATION:

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

I hereby authorize the physicians and/or employees of _____ to release medical information below.

Release records and information regarding:

_____ _____ _____
Name of Patient (List Other Names Used) *Medical Record #* *Date of Birth*

_____ _____
Address *Telephone Number*

Release medical information to: _____
Name of Receiving Party

_____
Address

_____
City, State, Zip Code

DURATION: This authorization shall become effective immediately and shall remain in effective until _____ (enter date) or for one year from the date of signature if no date entered.

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health Information unless another authorization is obtained from me or unless disclosure is Specifically required or permitted by law.

SPECIFY RECORDS: Check the box and initial which type of information is to be disclosed:

☐ **MEDICAL INFORMATION** (Last 5 years only) (Excludes HIV, Psychiatric and/or Substance Abuse Information)

☐ **PSYCHIATRIC INFORMATION**

_____ _____
Signature *Date*

☐ **DRUG/ALCOHOL INFORMATION**

_____ _____
Signature *Date*

☐ **HIV TEST RESULTS**

_____ _____
Signature *Date*

☐ ***OTHER*** *(specify):* _____

I request that the health information released pursuant to this authorization be used for the following purposes only:

_____

_____

A copy of this authorization is valid as an original.

I have a right to receive a copy of this authorization. The copy is for me to keep.

_____ _____
Date *Signature of Patient or Patient's Representative*

_____
Indicate Relationship (if Signed by Other Than Patient)

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PATIENT REGISTRATION FORM
REGISTRACION DEL PACIENTE

NAME (Nombre)_____

LAST NAME (Apellido)_____ Sex: ❑ Male ❑ Female

DATE OF BIRTH (Fecha de Nacimiento)_____ Sexo: ❑ Masculino ❑ Femenina

CIVIL STATUS: ❑ Single/Soltero ❑ Married/Casado ❑ Divorced/Divorciado ❑ Separated/Separado ❑ Widowed/Viudo

ADDRESS (Direccion) _____

CITY (Ciudad) _____ ZIP CODE (Zona Postal) _____

PHONE # (Numero de Telefono) _____

PATIENT S GUARANTOR (Persona Responsable) _____

SOCIAL SECURITY NO. (SS # / Numero de Seguro) _____

EMPLOYER S NAME (Nombre del Trabajo) _____

ADDRESS (Direccion) _____

CITY (Ciudad) _____ ZIP CODE (Zona Postal) _____

PHONE # (Numero de Telefono) _____ Ext. _____

IN CASE OF EMERGENCY NOTIFY TO (En Caso de Emergencia Notificara)

NAME (Nombre) _____ Relationship _____

PHONE # (Numero de Telefono) _____

INSURANCE COMPANY INFORMATION

INSURANCE COMPANYY NAME
(Nombre de la Aseguranza) _____

INSURANCE ID (# de Identificacion) _____

GROUP (Grupo #) _____

ADDRESS (Direccion) _____

CITY (Ciudad) _____ ZIP CODE (Zona Postal) _____

PHONE # (Numero de Telefono) _____ Ext. _____

AUTHORIZATION: To pay benefits to physician; I hereby agree payment of any insurance benefits covering these medical charges, directly to the Physician/Surgeon. I further understand that although I may have insurance, I am responsible for payment of this account regardless of insurance coverage.

INSURED S SIGNATURE: _____ DATE: _____

FIRMA DEL PACIENTE: _____ FECHA: _____