KabaFusion
Patient-Focused Infusion Therapy

MAIL, FAX, OR EMAIL COMPLETED FORM TO:
KabaFusion Holdings, LLC
Attn: Auditing & Medical Records
17777 Center Court Dr. N., Suite 550, Cerritos, CA 90703
Tel.: (800) 435-3020 ext.1225
Fax: (562) 286-8452
Email: Auditing_MedicalRecordsRequest@kabafusion.com

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

Please print all information clearly in order to process your request in a timely manner.

A. PATIENT INFORMATION:

PATIENT NAME: ______________________________ PATIENT DATE OF BIRTH: ____________

PATIENT MEDICAL RECORD #: ______________________________

PATIENT ADDRESS: STREET: ______________________________ APT. #: ____________

CITY: ____________________ STATE: ________ ZIP CODE: ____________

TELEPHONE CONTACT #: DAY: (_____) ____________________ EVENING: (_____) ____________________

B. PERMISSION TO SHARE:

I authorize KabaFusion Holdings, LLC and its affiliates (“**KabaFusion**”) to release my protected health information to the person or entity identified below as and to the extent described in Sections C through E of this form.

FROM: (*e.g.*, the name of KabaFusion Entity or Provider who will be release the information to the recipient)

Entity or Provider Name: ____________________

Address: ____________________

____

____

Telephone Number: ____________________

TO: (*e.g.*, to whom you would like the information sent)

☐ Check here if the records are to be mailed to the patient at the address identified above in Section A. Otherwise, please complete the information requested below to indicate where you would like the information sent:

Name: ____________________

Address: ____________________

____

____

Telephone Number: ____________________

SEND BY:

- ☐ Paper Copy via Mail
- ☐ Secure Email (provide email address): ____________________
- ☐ Fax (provide fax number): ____________________
- ☐ Other (provide method): ____________________

PURPOSE: (Select all that apply)

- ☐ Medical Care
- ☐ Insurance*
- ☐ Legal Matter*
- ☐ Personal *
- ☐ School
- ☐ Other* (please specify): ____________________

*Copying fees may apply

C. INFORMATION TO BE RELEASED:

Please check all that apply and specify dates.

- ☐ Medical Record Abstract/Dates ____________________
  (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)
- ☐ Clinic Visit Notes/Dates ____________________
- ☐ Discharge Summary/Dates ____________________
- ☐ Lab Reports/Dates ____________________
- ☐ Operative Reports/Dates ____________________
- ☐ Pathology Reports/Dates ____________________
- ☐ Radiation Reports/Dates ____________________
- ☐ Radiology Reports/Dates ____________________
- ☐ Photographs/Dates* ____________________
  **Costs may apply*
- ☐ Billing Records/Dates ____________________
- ☐ Other *(please specify below and include dates)*:
  ____
  ____

D. AUTHORIZATION:

Please check “Yes” in the applicable space below to indicate that you give permission to KabaFusion to release the following information if present in your record.

☐ Yes **HIV test results.** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST)
SPECIFY DATES ______________________________

☐ Yes **Genetic Screening test results**
SPECIFY TYPE OF TEST ______________________________

☐ Yes **Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2.**
FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2. THIS CONSENT MAY BE REVOKED UPON ORAL OR WRITTEN REQUEST.

☐ Yes **Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC).** I UNDERSTAND THAT MY PERMISSION MAY NOT BE REQUIRED TO RELEASE MY MENTAL HEALTH RECORDS FOR PAYMENT PURPOSES.

☐ Yes **Confidential Communications with a Licensed Social Worker**

☐ Yes **Details of Domestic Violence Victims’ Counseling**

☐ Yes **Details of Sexual Assault Counseling**

☐ Yes **Other** (Please List): ______________________________

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E. ACKNOWLEDGEMENT:

By signing below, I confirm that I understand and agree as follows:

1. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy laws, including HIPAA. I understand that KabaFusion is not responsible for ensuring that any recipient of my Protected Health Information will further use and/or disclose the information for the purposes identified above.
2. Notwithstanding the foregoing, if the health information described above includes information relating to the treatment of drug and alcohol abuse, this authorization may allow the disclosure of drug and alcohol treatment information, except psychotherapy notes, if I have authorized such disclosure by selecting "Yes" in the appropriate space in Section D, above. I understand that the recipient of this information may not redisclose alcohol and drug treatment information without my explicit consent unless otherwise permitted under applicable law.
3. This authorization is voluntary, and I may refuse to sign it. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure or signing of this form.
4. I acknowledge I have the right to revoke this authorization at any time by contacting KabaFusion. I understand that my revocation must be in writing. I also understand that my revocation will be valid except to the extent that KabaFusion has taken action in reliance on the authorization before it is revoked (*e.g.*, once information has been released, it cannot be retrieved by KabaFusion).
5. This authorization will automatically expire **six (6) months from the date of signature indicated below**, unless otherwise specified as follows (provide expiration date, if applicable):________________________.
6. If KabaFusion maintains any of my records from outside providers, these will not be released unless I specifically ask for them under "Other" in Section C, above. Please include entity name, provider, and specific dates, if known.
7. My questions about this authorization form have been answered.

F. SIGNATURES:

Patient's Signature: ____ **Date:** ________________________

Print Name: ____

If the patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Legal Representative's Signature: ____________________________ **Date:** ________________________

Print Name: ______________________________ **Relationship to Patient:** ___________________________

FOR INTERNAL USE ONLY			
Request Received By:	____________________	Date Received:	____________________
Records Released By:	____________________	Date Released:	____________________