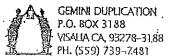
## Authorization for Release of Information

(NAME OF PHYSICIAN OR HEALTH CARE PROV	VIDER AUTHORIZED TO USE OR DISCLOSE INFORMATION)
hereby requests and directs you by the Information Act, Welfare and Institutio Health Insurance Portability and Accounto release the information described belong. Germini Duplication, Inc. is author	or the patient's personal or legal representative authority of the confidentiality of the Medica on Code Sections 5328 and 42 CFR 2.3, et seem tability Act of 1996 (HIPAA) 45 C.F.F 164 ow to a representative of Gemini Duplication ized by the patient and/or the patient's to receive the information pertaining to:
Patient / Employee:	
AKA:	
Social Security No:	Date of Birth:
Representing Attorney:	
and extent of a claim for injuries and disbenefits, expenses, compensation and da This information is limited to the follo (Any and All Information unless otherw	owing type and amount of information.
appropriate)  Any and all Medical Records Consultation Reports Progress Notes Laboratory, Pathology Reports Radiology / Imaging Reports Actual X-Rays, MRI's, CT Scans Personnel & Wage Records Other:	For the last years Patient Billing Information Immunization Records From To From To
	Initials/Consent

This authorization conforms to California Civil Code Section 56.1.1 and 164.508 – pg. 82811 of the Federal Register, Dec. 28, 2000; California Welfare and Institutions Code Sections 5328, 42 CFR 2.31, and all Health Information Portability and Accountability Act of 1996 (HIPAA) 45 C.F.F. 164 requirements.



## DISCLOSURE REQUIRING SPECIAL CONSENT

My signature below specifically authorizes the release of healthcar	e information
relating to the testing,	
Diagnosis or treatment for: (initial appropriate areas)	
HIV/AIDS virus	
Mental Health/Psychiatric Disorders	
Sexually Transmitted Diseases	
Drug, Alcohol Abuse/Treatment	
Right to Revoke: I understand that I have a right to revoke this aut	norization at
any time. I understand that my revocation must be in writing and prese	nt to the
Health Information Management Department. I understand that the rev	ocation will
not apply to information that has already been released in response to th	is
authorization. I understand that the revocation will not apply to my insu	rance
company when the law provides my insurer with the right to contest a c	aim under my
policy. Unless otherwise revoked, this authorization will expire on the	ollowing date
event or condition:	
Expiration: If a specific expiration or event is not provided, this aut	horization
shall remain valid for a period of one year from the date signed and a co	py of this
authorization is as valid as the original. An original authorization is n	ot required to
be shown.	
North on two at more and in a series and in the series of	
Neither treatment, payment, enrollment or eligibility for benefits wil	l be
conditioned on my providing or refusing to provide this authorization. I	understand
that I may inspect or copy the information to be used or disclosed as provided 524. I and another different statements of the control of the	rided in CFR
164.524. I understand that any disclosure of information carries with it t	ne potential
for an unauthorized re-disclosure by the recipient and the information ma	y not be
protected by federal confidentiality rules. If I have questions about discless the line formation. I can contact the Director is III. It I is	osure of my
health information, I can contact the Director of Health Information. I un	iderstand·1.
have a right to receive a copy of this authorization.	<b>.</b>
	•
(Signature of patient, parent and/or legal guardian)	D /
(Dignature of patient, parent and/or legal guardiam)	Date
	•
(If signed by other than patient, indicate relationship)	Dota
(	Date

This authorization conforms to California Civil Codé Section 56.11 and 164.508 -- pg. 82811 of the Federal Register, Dec. 28, 2000; California Welfare and Institutions Code Sections 5328, 42.CFR 2.31, and all Health Information Portability and Accountability Act of 1996 (HIPAA) 45 C.F.F 164 requirements.

