Southern California Multi-Specialty Center
5805 Sepulveda Blvd. Suite 690 Sherman Oaks, CA 91411

PLEASE PRINT VERY CLEARLY

Line items printed in **bold** on this page are required fields if they apply.

Patient Information

Full Name: ______________________________ **Date of Birth**:__________
(First) (Middle) (Last)

Gender: ☐ Male ☐ Female **Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: ______________ Apt #: ________ **City**: ____________ **State**: _____ **Zip**: ________

Phone Number: ☐ Home: ____________________ ☐ **Cell**: ________________

Email: ______________________________

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐Unknown/Declined

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Unknown/Declined

Preferred Language: ☐ English ☐ Spanish ☐ Chinese (Cantonese) ☐ Chinese (Mandarin) ☐ French ☐ German ☐ Italian ☐ Japanese ☐ Portuguese ☐ Russian ☐ Other

Employer: ______________________ **Employer Phone**: ________________

Guarantor if not the Patient (Financially Responsible Party for Minor or Incapacitated Adult)

Full Name: __________________**Date of Birth**:________ **Relationship to Patient**: __________

Address: ______________ Apt #: ________ **City**: ____________ **State**: _____ **Zip**: ______

Phone Number: ☐ **Home**: ______________ ☐ **Cell**: ____________ **Email:** ______________

* By providing a phone number or email address, you are consenting to being contacted at that number or address regarding your treatment or billing information

Emergency Contact Information and Relationship to Patient

Name: ____________________ **Relationship:** ____________ **Phone:** ________________

Name: ____________________ **Relationship:** ____________ **Phone:** ________________

* The information is confidential and is covered by the provisions of the *Freedom of Information and Protection of Privacy Act.*

	Primary Insurance	**Secondary Insurance**
Name of Insurance	________________	________________
Policy Holder Name/DOB	________________	________________
Policy Holder Relationship to Patient	________________	________________
Policy/Member ID Number	________________	________________
Group/Plan Number	________________	________________

Does your Insurance Require a Referral? ☐ YES ☐ NO

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Patient Name: ____ **Date of Birth:** ____________________

Referring Physician Information

Physician Name: ____________________ Specialty: ____________________ Office Name: ____________________

Address: ____________________ Phone: ____________________ Fax: ____________________

Primary Care Physician Information (if different than referring physician)

Physician Name: ____________________ Specialty: ____________________ Office Name: ____________________

Address: ____________________ Phone: ____________________ Fax: ____________________

Other Specialty Care Physicians

Nephrology:

Physician Name: ____________________ Office Name: ____________________ Location: ____________________

Address: ____________________ Phone: ____________________ Fax: ____________________

Hematology/Oncology:

Physician Name: ____________________ Office Name: ____________________ Location: ____________________

Address: ____________________ Phone: ____________________ Fax: ____________________

Cardiology:

Physician Name: ____________________ Office Name: ____________________ Location: ____________________

Address: ____________________ Phone: ____________________ Fax: ____________________

Endocrinology:

Physician Name: ____________________ Office Name: ____________________ Location: ____________________

Address: ____________________ Phone: ____________________ Fax: ____________________

Gastroenterology:

Physician Name: ____________________ Office Name: ____________________ Location: ____________________

Address: ____________________ Phone: ____________________ Fax: ____________________

Surgery:

Physician Name: ____________________ Office Name: ____________________ Location: ____________________

Address: ____________________ Phone: ____________________ Fax: ____________________

Other:

Physician Name: ____________________ Office Name: ____________________ Location: ____________________

Address: ____________________ Phone: ____________________ Fax: ____________________

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Patient Name: ____ **Date of Birth:** ____________________

Pharmacy Information

Pharmacy Name: ________________________________ Phone: ____________________ Fax: ______________________

Pharmacy Address:____

Dialysis Center

Dialysis Center Name: ____ Location: ____________________________

Dialysis Center Address: ______________________________Phone: ___________________________ Fax: ____________

Medications Causing Bruising/Bleeding

Aspirin.. ☐ Yes ☐ No
Warfarin / Coumadin.................................... ☐ Yes ☐ No
Plavix .... ☐ Yes ☐ No
Eliquis .... ☐ Yes ☐ No
Xarelto .... ☐ Yes ☐ No

Nonsteroirdal Anti-inflammatory (NSAIDs)

Advil... ☐ Yes ☐ No
Alleve.. ☐ Yes ☐ No
Bextra .... ☐ Yes ☐ No
Celebrex .... ☐ Yes ☐ No
Ibuprofen .... ☐ Yes ☐ No

Herbal Supplements/Vitamins

Fish oil .... ☐ Yes ☐ No
Vitamin E .... ☐ Yes ☐ No
Gingko Biloba .... ☐ Yes ☐ No

Brilinta .... ☐ Yes ☐ No
Cilostazol .... ☐ Yes ☐ No
Aggrenox.. ☐ Yes ☐ No
Pradaxa.. ☐ Yes ☐ No
Prasugrel.. ☐ Yes ☐ No

Nonsteroirdal Anti-inflammatory (NSAIDs)

Mediprin .... ☐ Yes ☐ No
Motrin .... ☐ Yes ☐ No
Naproxin... ☐ Yes ☐ No
Nuprin .... ☐ Yes ☐ No
Vioxx .... ☐ Yes ☐ No

Herbal Supplements/Vitamins

Flax Seed.. ☐ Yes ☐ No
Omega 3 supplements................................. ☐ Yes ☐ No
Ginseng.. ☐ Yes ☐ No

Surgeries

Balloons/Stents ....Date: ____________
Aneurysm Surgery...........................Date: ____________
Carotid Surgery...............................Date: ____________
Heart / Bypass.................................Date: ____________
Joints (Hip / Knee) ....Date: ____________
Back / Neck ....Date: ____________
Hospital Stay .... Date: ____________

Gallbladder......................................Date: ____________
Appendectomy.................................Date: ____________
Hernia..Date: ____________
Hemorrhoid...................................... Date: ____________
Hysterectomy................................... Date: ____________
Breast .... Date: ____________
Eye / Ear / Nose / Throat.................. Date: ____________

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Current Condition

Constitutional Symptoms

- Good general health lately ☐ Yes ☐ No
- Recent weight gain ☐ Yes ☐ No
- Recent weight loss ☐ Yes ☐ No
- Fever ☐ Yes ☐ No
- Fatigue ☐ Yes ☐ No

Allergic / Immunologic

Skin reaction or other adverse reaction to:

- Penicillin or another antibiotic ☐ Yes ☐ No
- Morphine, Demerol, or other narcotics ☐ Yes ☐ No
- Novocain or other anesthetics ☐ Yes ☐ No
- Aspirin or other pain remedies ☐ Yes ☐ No
- Tetanus antitoxin or other serum ☐ Yes ☐ No
- Iodine, Merthiolate or other antiseptic ☐ Yes ☐ No
- CT or MRI contrast injection ☐ Yes ☐ No

Hematologic / Lymphatic

- Slow to heal after cuts ☐ Yes ☐ No
- Bleeding or bruising tendency ☐ Yes ☐ No
- Anemia ☐ Yes ☐ No
- Phlebitis ☐ Yes ☐ No
- Enlarged glands ☐ Yes ☐ No
- History of DVT ☐ Yes ☐ No
- History of pulmonary embolism ☐ Yes ☐ No
- Family history of clotting or bleeding disorder ☐ Yes ☐ No

Integumentary (skin, breast)

- Rash or itching ☐ Yes ☐ No
- Change in skin color ☐ Yes ☐ No
- Change in hair or nails ☐ Yes ☐ No
- Varicose veins ☐ Yes ☐ No
- Breast pain ☐ Yes ☐ No
- Breast lump ☐ Yes ☐ No
- Breast discharge ☐ Yes ☐ No

Endocrine

- Glandular or hormone problem ☐ Yes ☐ No
- Thyroid disease ☐ Yes ☐ No
- Diabetes ☐ Yes ☐ No
- Excessive thirst or urination ☐ Yes ☐ No
- Heat or cold intolerance ☐ Yes ☐ No
- Skin becoming drier ☐ Yes ☐ No
- Change in hat or glove size ☐ Yes ☐ No
- History of dialysis ☐ Yes ☐ No

Cardiovascular

- Heart trouble ☐ Yes ☐ No
- Chest pain or angina pectoris ☐ Yes ☐ No
- Palpitations ☐ Yes ☐ No
- Short of breath when walking ☐ Yes ☐ No
- Short of breath when lying down ☐ Yes ☐ No
- Swelling of feet, ankles, or hands ☐ Yes ☐ No

Respiratory

- Chronic or frequent cough ☐ Yes ☐ No
- Spitting up blood ☐ Yes ☐ No
- Shortness of breath ☐ Yes ☐ No
- Difficulty breathing ☐ Yes ☐ No
- Sneezing ☐ Yes ☐ No

Gastrointestinal

- Loss of appetite ☐ Yes ☐ No
- Change in bowel movements ☐ Yes ☐ No
- Nausea or vomiting ☐ Yes ☐ No
- Frequent diarrhea ☐ Yes ☐ No
- Painful bowel movements ☐ Yes ☐ No
- Constipation ☐ Yes ☐ No
- Rectal bleeding or blood in stool ☐ Yes ☐ No
- Abdominal pain or heartburn ☐ Yes ☐ No
- Peptic ulcer (stomach or duodenal) ☐ Yes ☐ No

Genitourinary

- Frequent urination ☐ Yes ☐ No
- Burning or painful urination ☐ Yes ☐ No
- Blood in urine ☐ Yes ☐ No
- Change in force or strain when urinating ☐ Yes ☐ No
- Incontinence or dribbling ☐ Yes ☐ No
- Kidney stones ☐ Yes ☐ No
- Sexual difficulty ☐ Yes ☐ No
- Men: testicle pain ☐ Yes ☐ No
- Women: painful periods ☐ Yes ☐ No
- Women: irregular periods ☐ Yes ☐ No
- Women: vaginal discharge ☐ Yes ☐ No

Musculoskeletal

- Joint pain ☐ Yes ☐ No
- Joint stiffness or swelling ☐ Yes ☐ No
- Weakness of muscles / joints ☐ Yes ☐ No
- Back pain ☐ Yes ☐ No
- Cold extremities ☐ Yes ☐ No
- Difficulty in walking ☐ Yes ☐ No

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Current Condition Continued

Eyes

Eye disease or injury	☐ Yes	☐ No
Wears glasses or contact lenses	☐ Yes	☐ No
Blurred or double vision	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No

Ears / Nose / Throat / Mouth

Hearing loss or ringing	☐ Yes	☐ No
Earache or drainage	☐ Yes	☐ No
Chronic sinus problem / rhinitis	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No
Mouth sores	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Bad breath or taste in mouth	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Voice change	☐ Yes	☐ No
Swollen glands in neck	☐ Yes	☐ No

Neurological

Frequent or recurring headaches	☐ Yes	☐ No
Lightheaded or dizzy	☐ Yes	☐ No
Convulsions or seizures	☐ Yes	☐ No
Numbness or tingling sensation	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Head injury	☐ Yes	☐ No

Psychiatric

Memory loss or confusion	☐ Yes	☐ No
Nervousness	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No

Health Problems

	Yes	No
Stroke	☐	☐
Heart Disease	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Emphysema	☐	☐
Tuberculosis	☐	☐
Pneumonia	☐	☐
Bleeding / Clotting Problems	☐	☐
Speech / Hearing Problems	☐	☐
Other ______________________________	☐	☐

	Yes	No
Allergies	☐	☐
Kidney Disease	☐	☐
Jaundice / Hepatitis	☐	☐
High Blood Pressure	☐	☐
Cancer	☐	☐
Back Problems	☐	☐
Arthritis	☐	☐
Stomach / Ulcer Problem	☐	☐
Diabetes	☐	☐
Blood Transfusion (Dates: ________________)	☐	☐

Family History

	Yes	No
Heart Disease	☐	☐
Diabetes	☐	☐
High Blood Pressure	☐	☐

	Yes	No
Cancer	☐	☐
Stroke	☐	☐
Other: ____________________	☐	☐

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POLICIES AND PROCEDURES

Health Insurance Cards: Please bring your most current health insurance membership card to each appointment. Intentionally failing to notify us of changes to your insurance coverage may constitute insurance fraud, and we may be obliged to report it to the authorities.

Keeping Appointments: Appointments must be cancelled with at least 1 full business days' notice for office appointments, and 3 full business days' notice for surgical procedures. Failure to show for an office visit, or cancellation on less than 24 hours' notice, constitutes a no-show and is subject to a $20 fee. Failure to show for a surgical procedure, or cancellation on less than 3 days' notice, constitutes a no-show and is subject to a $250 fee. Cancellation due to lack of referral (see below) is considered a no-show. You may be dismissed as a patient by our practice for failure to meet your financial obligations. _______ **Initials**

Health Insurance Plans: Although we may advise you whether we believe we participate with your insurance carrier, we are not responsible for any assurances made to you regarding whether particular services rendered in this practice are covered by your plan. You and you alone are responsible to understand the provisions of your health insurance plan and coverage. We recommend contacting your carrier prior to receiving services to verify your financial responsibilities and our participation status in your specific network.

Referrals and Prior Authorizations: You are responsible to obtain all necessary referrals prior to your appointment, if required by your health plan. We will do our best to ensure you have one if you need one, but the ultimate responsibility is yours. If your plan requires a referral or authorization that you do not obtain, and your health plan refuses to pay for any claim for lack of a referral or authorization, you explicitly agree to be responsible for our charges for any affected visits, even if the provisions of your plan stipulate you otherwise wouldn't be (you are waiving that defense). If you come to an appointment without a required referral, and you must reschedule, the canceled visit may be considered a no-show, as above.

Medicare: If you have coverage with original Medicare (this means Medicare directly from the government) or Medicare Advantage (this means Medicare provided through a commercial carrier) it is your responsibility to understand the provisions of your health insurance plan and coverage. Every original Medicare beneficiary is responsible for an annual deductible and a 20% coinsurance. Any portion of this deductible and coinsurance that is not covered by a supplemental carrier will be your financial responsibility to pay. You are wholly responsible for your coverage limitations, regardless of whether you are aware of the details. If you have both Medicare and another insurance, you are responsible for providing the correct primary insurance at your visit. If you have supplemental insurance that does not cross over automatically, and/or is not paid within 60 days from the date of service, you will be billed for the deductible and coinsurance, and you may be given a receipt to submit yourself. By signing below, you specifically agree to these terms, and exempt yourself from any protections your insurance plan may offer you regarding this provision.

In-Network Commercial Insurance: If you have an insurance plan with which the provider does participate, and under which you have in-network benefits, we shall file claims with the insurance carrier and, upon receipt of carrier adjudication, will invoice you for any balance which may be applied to your financial responsibility. If your plan has a copayment, it is your responsibility to pay it in full at the time of service, even if the amount it not printed on your insurance card. Please have your payment ready upon check-in. Please be aware that, should you not pay your copayment at the time of service, you will be responsible to pay an invoice fee of $15. If your insurance carrier advises us that the amount of your copayment is higher than what is printed on the card you provide, you are responsible for payment of the difference. If your plan advises us at any time that you do not have coverage for the services rendered, or your policy is exhausted, or you are not covered for services rendered for any reason, even retroactively, you will be responsible for the entire balance.

Out-of-Network Commercial Insurance: If you have an insurance plan with which we do not participate, but under which you have out-of-network benefits, we may agree to file claims for services rendered. You may be required to pay for some or all of the charges upfront toward your obligation for services rendered, and after receiving the insurance carrier adjudication we may bill you for the balance.

If your plan advises us at any time that you do not have coverage for the services rendered out-of-network, or your policy is exhausted, or you are not covered for services rendered for any reason, you will be responsible for the entire balance. If your plan issues payment to us for services rendered out-of-network, you may be responsible for some or all of the balance, which we will invoice you for. If your plan makes payment directly to the patient or policy holder for services rendered, you are responsible to turn the entire payment over to us immediately upon receipt, by endorsing the check over to Southern California Multi-Specialty Center, along with a complete copy of the Explanation of Benefits. Should you be issued payment by the insurance carrier and not promptly turn it over to us in whole,

legal action will be pursued, and you may be discharged as a patient from this practice. After turning over the insurance carrier's payment, you may remain responsible for some or all the balance, which we will invoice you for. We may only submit claims to your primary insurance – you may be given a receipt which you can submit to secondary insurance. Balance bills are due immediately upon receipt.

Health Insurance Non-Payment: Services that have not been paid by your health insurance carrier within 60 days of claim submission will become your financial responsibility to pay in full. In cases of retroactive disenrollment, you are responsible immediately upon notification to us by the carrier. This policy applies equally to in-network and out-of-network plans. If your insurance carrier later makes payment on such a claim, you will be reimbursed for your payment, minus any amount which has been applied to your financial responsibility by your in-network insurance carrier.

Balances and Collections: It is our right and responsibility to bill you for any portion of your treatment your medical insurance assigns to your responsibility. It is your responsibility, as detailed by the terms of your health insurance policy, to pay any such portion. If you do not remit full payment on any such bills within a reasonable period and with reasonable notice, your account may be sent to collections. If that happens, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys' fees, which we incur in such collection efforts. If you bounce a check, you will be responsible for a $35 fee, and will not be able to pay by personal check again. You may be dismissed as a patient by our practice for failure to meet your financial obligations.

Self-pay patients: If you do not have health insurance or are receiving services known to not usually be covered, it is our policy that you must pay for those services before leaving the office. If you have insurance through an out-of-network insurance to which we do not agree to submit claims on your behalf, you may ask for a receipt at the time of service.

Smoke Free Environment: Southern California Multi-Specialty Center is a smoke free environment. Smoking (including smokeless tobacco, electronic cigarettes, and vaping, regardless of tobacco content) is prohibited at any of our locations.

Weapon Free Environment: Southern California Multi-Specialty Center strives to maintain an environment free from violence and intimidation. Weapons of any kind are prohibited on all our properties, apart from authorized law enforcement officers. For the purposes of this policy, weapons are defined as any implement or tool whose primary function is to cause bodily harm to the person against whom it is used.

Energy Fields: Southern California Multi-Specialty Center and its subsidiaries render services at locations (including but not limited to those owned and rented by it/them) which contain hazardous energy fields or radiation, such as x-rays. Patients who are pregnant (including those who think they may be pregnant) and/or susceptible to radiation should notify the medical staff. By signing below you hereby release the owners, physicians and staff of Southern California Multi-Specialty Center and its subsidiaries from all suits, claims, liability, or demands of every kind and character which you or your heirs, executors, administrators or assigns hereafter can, shall, or may have arising out of your presence at any of these locations.

Laboratory Testing: If you are a member of an insurance plan that requires you to have your laboratory specimens sent to a particular laboratory, and this office is so informed by you, we will happily send your specimens to that laboratory, unless the provider determines that another laboratory is preferred for medical reasons. However, regardless of which laboratory patient specimens are sent to for analysis, you are entirely responsible for all charges assessed by the laboratory and shall handle financial matters directly with the laboratory.

Privacy: A person is liable for constructive invasion of privacy when they attempt to capture any type of visual image, sound recording or other physical impression of another individual engaging in a personal or familial activity under circumstances in which that individual had a reasonable expectation of privacy. A person who violates these provisions would be subject to a civil fine of not less than $5,000 and not more than $50,000 [California Civil Code, Section 1708.8]. Southern California Multi-Specialty Center complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

I have read, fully understand, accept, and agree to comply with all the above provisions, policies and conditions. I consent to the assignment of authorized health insurance benefits by my health insurer to Southern California Multi-Specialty Center (and its subsidiaries) for any services furnished to me or my dependents. I authorize any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original.

Patient Name (Please print clearly): ____

Signature of Patient: ____ Date: ______________________

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Assignment & Release

I, (print name of patient or legal guardian) ___________________, authorize payment directly to Southern California Multi-Specialty Center (and/or its subsidiaries, including Southern California Hepatobiliary Pancreatic and Robotic Surgery Institute, and Southern California Vein & Artery Specialists, Inc) of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. If my insurance plan requires an authorization or referral, and I do not obtain one for the services I receive, I understand that I am responsible for all charges, even if the provisions of my plan stipulate I otherwise wouldn't be. I authorize any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agree to the above.

- Patient/Guarantor Signature: _______________________________________ Date: ____________________

In the event of an emergency, I, (print name of patient or legal guardian) ___________________, hereby authorize and give my permission directly to Southern California Multi-Specialty Center (and/or its subsidiaries, including Southern California Hepatobiliary Pancreatic and Robotic Surgery Institute, and Southern California Vein & Artery Specialists, Inc) to contact and inform the above listed individuals and reveal my personal information in regards to treatments, procedures(s), surgery and other relevant facts and interventions pertaining to my care. I have read and agree to the above.

- Patient/Guarantor Signature: _______________________________________ Date: ____________________

PATIENT CONSENT TO PHOTOGRAPHY

The Department of Health and Human Services has established a provision known as the Privacy Rule, as a result of passage of the HIPAA law and its omnibus. It was created to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of protected health information.

As our patient, we want you to know that we respect the privacy of your personal medical records and will take all reasonable efforts to secure and protect that privacy in compliance with the law. Part of your treatment may include photographs and/or video of your face and/or other body parts. These may be used by our office for treatment or educational purposes. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel need your healthcare information and information about treatment, payment, or healthcare operations, to provide healthcare that is in your best interest. Part of your treatment may include photographs and/or video of your face and other body parts.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. If you choose to give consent in this document, at some future time you may request to refuse all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

The photos If you have any concerns about this policy or form, please ask to speak with our HIPAA Compliance Officer.

INFORMED CONSENT TO PHOTOGRAPH

I, (print name of patient or legal guardian) _______________________________________, do hereby give consent to Southern California Multi-Specialty Center, and its subsidiaries, to take and/or display photographs and/or video of the patient's face and other body parts. The photographs or video will be used as part of medical information and/or educational purposes by Southern California Multi-Specialty Center and/or its subsidiaries. The doctors and office staff will protect my personal data, such as name, age, and date of birth, from being displayed.

I further understand that if the photograph(s) and/or video are used, I do not expect compensation, financial or otherwise, of the use of these photographs and/or video and waive all such rights.

- Patient/Guarantor Signature: ___________________________________ Date: _________________ Witness: _____________

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PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

♦ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.

♦ I agree that telephone messages regarding my appointments, prescription renewals, test results, and all other Protected Health Information* ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: ___________________

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: ___________________

♦ I agree that my PHI may be shared with my spouse (if applicable), other medical providers, and the following other people (if applicable).

_______________________________________ _______________________________________

_______________________________________ _______________________________________

♦ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Southern California Multi-Specialty Center to the attention of the HIPAA Compliance Officer.

♦ I agree that Southern California Multi-Specialty Center and its subsidiaries may contact me at any email addresses provided to you by me regarding both PHI and non-PHI.

**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name: ____ Date: ____________________

♦ Signature of Patient: ____

MEDICAL RECORDS RELEASE

I hereby request protected health information to be released from the medical record of:

Patient Name: _______________________________ **Date of Birth:** __________________

Release Records From: ____

Send Records To:
Southern California Multi-Specialty Center
5805 Sepulveda Boulevard
Suite 690
Sherman Oaks CA 91411-2522
Fax: (818) 900-6488

This request and authorization apply to: *(check appropriate selection)*

☐ All healthcare information.

☐ Only healthcare information relating to the following treatment, condition, or date(s): __________________________

I hereby authorize and request the prompt release of medical records without exception, including but not limited to clinical notes, lab tests, pathology reports, radiology reports, messages, prescriptions, consultations, and secondary records.

Patient Name: ____ Date: ____________________

♦ Signature of Patient: ____