ER FAX 459-1531
PHY THERAPY FAX 459-2789
NURSES STN FAX 459-9350
X-RAY FAX 459-9226
LAB FAX 459-3373
HEALTH INFO FAX 459-3163

ONE MARCELA DR
WILLITS, CA 95490
PHONE: 459-6801

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: ______________________ **Date of Birth**: ______________

Address **Phone**

City/State/Zip **Cell**

Please obtain my medical information from ☐ or send to ☐:	**For the Purpose of**: ☐ Patient Care ☐ Insurance Claim ☐ Self ☐ Other
Name of physician, facility, or other	**List specific dates of records to be released**:
City/State/Zip Telephone Number Fax Number	**Duration**: This authorization shall begin immediately and remain in effect until: **If no date entered, duration will be 1 (one) year.**

I AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS: ______________

____

Please check if additional information is to be included:

☐ Psychiatric/behavioral health diagnosis or treatment.

☐ HIV/AIDS test results.

☐ Drug/alcohol records

I understand that such information cannot be released without my specific consent.

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected. *(Under California law, however, a recipient of medical information, whether disclosed pursuant to an authorizations or to the discretionary provisions of California Civil Code #56.10(x), may not further disclose that medical information except in accordance with a new authorization or as specifically required or permitted by law.)*

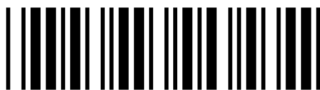
Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment (see page 2 of this form for certain exceptions). I may inspect or obtain a copy of any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing (see page 2 of this form). My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization. I have t right to obtain a copy of this authorization.

Signature: ____

(Patient/Parent/Conservator/Guardian) Date Time

If signed by other than patient, indicate relationship: ______________________

Witness: ______________________



PATIENT LABEL

ER FAX 459-1531
PHY THERAPY FAX 459-2789
NURSES STN FAX 459-9350
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HEALTH INFO FAX 459-3163

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

**************************** **For Office Use Only** ****************************

Date Received: ________________________ Date Records Sent: ________________________

☐ Identity of Individual and/or Parent/Conservator/Guardian

Notes: ____

_________________________ _____________________

Medical Record Number Clerk Initials

*************************** **Revocation of Authorization** ***************************

In accord with provisions of the Notice of Privacy Practices, I hereby revoke the

☐ **Above Authorization**

☐ **Authorization releasing information to** ________________________________

☐ **Authorization dated**

Signature: ____

(Patient/Parent/Conservator/Guardian) Date Time

If signed by other than patient, indicate relationship: __________________________

Witness: ____

**************************** **For Office Use Only** ****************************

Date Revocation Received: __________________________

☐ Identity of Individual and/or Parent/Conservator/Guardian

____________________________ __________________

Medical Record Number Clerk Initials

Exceptions: The exceptions noted in the Rights section on page 1 of this form include: authorization for research; authorization for health plan enrollment; and authorization solely for the purpose of creating protected health information for a third party.