Patient name _____ Date of Birth _____

Address _____ SS# _____

City/State/Zip _____ Phone _____

I hereby authorize _____

(name of facility) to release health information to

Name of physician/ hospital/other _____

Address _____ City _____ State _____ Zip _____

Phone #_____ Fax # _____

the following information: (all dates will be released unless specified).

Date(s) needed _____

❑ Discharge Summary ❑ History & Physical ❑ ER Record ❑ Consultations

❑ Operative Report ❑ Physician Orders ❑ Physician Notes ❑ Diagnostic Tests

❑ Other _____

I authorize the release of the following type of special information (initial all that apply):

_____ HIV test results _____ Mental health treatment _____ Alcohol/drug treatment

Purpose of request: ❑ Personal ❑ Insurance ❑ Disability ❑ Continuing Care

This authorization expires one (1) year from the date signed unless otherwise specified. Insert specified date/event _____

I prefer to receive the information by: ❑ Pick up ❑ Mail ❑ Fax ❑ Other _____

DATE _____ TIME _____ SIGNED _____
(Patient/Parent/Conservator/Guardian)

If signed by other than patient, indicate relationship_____

WITNESS _____

Revocation of Authorization on reverse side

Patient Identification

Client name _____

Medical Record #_____

* **For Office Use Only** *

I, the undersigned (e.g. physician, licensed psychologist, MSW / MFT), who is in charge of the patient, hereby ❑ approve ❑ disapprove the release of information and records to the party specified above. If disclosure is disapproved, give reasons below. Also note below any restrictions on the release of records. Note: No approval is required for release to the patient's attorney.

_____

_____

DATE _____ TIME _____ SIGNED _____ TITLE ____

Reference: Welfare and Institutions Code Section 5328.7
Reference: CFR Title 42, Part 2

Date received _____ Date records sent:_____ Medical record # _____

Notes _____

_____

_____ Clerk's 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 _____

DATE _____ TIME _____ SIGNED _____
(Patient/Parent/Conservator/Guardian)

If signed by other than patient, indicate relationship_____

WITNESS _____

* **For Office Use Only** *

Date revocation received_____ Medical record # _____ Clerk's 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.

Patient Identification

Client name _____

Medical Record #_____