

State of CA

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Patient	
Address	
Phone Number	E-mail
Birthdate	Social Security Number
Other Aliases	

Name of Guardian or Legal Representative	
Address	
Phone Number	E-mail

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release (Check one) all health information about me my medical records as described on the following page:

Person/Organization to Release Information		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	



The following persons/organizations are hereby authorized to receive my entire medical record, treatment record and diagnostic record:

Person/Organization to Receive Information		
Street Address		
City	State	Zip Code
Phone Number	email	

Person/Organization to Receive Information N/A		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

Person/Organization to Receive Information N/A		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	



The following health information that relates to service beginning from _____ [Date] to _____ [Date], may be released: (Check one)

Entire medical record (including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers)

Only the following: (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Patient histories | <input type="checkbox"/> Referrals |
| <input type="checkbox"/> Office notes (except psychotherapy notes) | <input type="checkbox"/> Consults |
| <input type="checkbox"/> Test results | <input type="checkbox"/> Billing records |
| <input type="checkbox"/> Radiology studies | <input type="checkbox"/> Insurance records |
| <input type="checkbox"/> Films | <input type="checkbox"/> Records sent by other health care provide |
| <input type="checkbox"/> Other: _____ | |

I further understand that my medical record may include one or more of the following:
(Check all that apply)

- Treatment of communicable diseases, including sexually-transmitted diseases, tuberculosis, or hepatitis
- Treatment related to AIDS/HIV
- Mental health treatment or psychological conditions
- Alcohol or substance abuse treatment
- Genetic testing
- Other: _____

The above person/organization, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of: (Check all that apply)

- Change of doctor
- Individual request
- Workers compensation
- Specialist referral
- Insurance purposes
- Continued treatment
- Legal investigation
- Other: _____



I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for _____ (Check one) days months years following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

_____	_____	_____
Patient's Signature	Patient's Name	Date

_____	_____	_____
Guardian or Legal Representative's Signature	Guardian or Legal Representative's Name	Date

