MEDICAL RECORD RELEASE AUTHORIZATION

PLEASE PRINT CLEARLY

PATIENT NAME: _____

ADDRESS: _____

PHONE #:_____BIRTHDATE: _____

1. I AUTHORIZE THE USE OR DISCLOSURE OF THE ABOVE NAMED INDIVIDUAL'S HEALTH INFORMATION AS DESCRIBED BELOW:
2. The following individual or organization is authorized to make the disclosure:
   Facility/Dr. Office Name: _____
   Address: _____
   Phone #: _____
3. For the purpose of review/examination and further authorize you to provide such copies of the records as may be requested. The foregoing is subject to such limitation as indicated below:
   _____ Entire Record _____ Substance Abuse
   _____ Psychiatric/Mental Health Information _____ HIV Information
   Specific Information: _____
4. This information may be disclosed to and used by the following individual or organization:
   Facility/Dr. Office Name: _____
   Address: _____
   Phone #: _____
   Reason for request: _____
5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing and present my written revocation to the clinic. I understand that the revocation will not apply to information that has already been released in response to this authorization.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

   This authorization will automatically expire six (6) months from the date signed, unless otherwise indicated or revoked. I understand that I may revoke this consent at any time except to the extent that action has been taken in reasonable reliance upon the document.

_____

Signature of Patient or Legal Representative Date

_____

Signature of Witness Date

It is the policy of this medical practice that we will adopt, maintain, and comply with our Notice of Privacy Practices, which shall be consistent with HIPAA and California Law.